How treatment is possible in the absence of a concept of mental disorder

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Declaration

Unless otherwise specified to the contrary, this dissertation is the result of my own work.

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Thesis supervisor's approval of this thesis for submission

As Michael Pitchford's supervisor I have approved this dissertation for submission

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Abstract

Commonly it is accepted that one of the advantages of the concept of mental disorder is its necessity when it comes to practical treatment issues. It is for this and other practical reasons that the concept of mental disorder is so ubiquitous. However since the adoption of mental disorder by psychiatry there have been sceptics. In recent years there has been a push to abandon the concept of mental disorder citing problems with validity and reliability of any concept that proposes a clear boundary between the normal and the abnormal. There are many potential arguments that a proponent of mental disorder could raise in objection to such a position. One of these arguments is that the concept of mental disorder is necessary for practitioners to provide the most effective treatment, thereby emphasising the necessity of the concept. One response available to these arguments is to argue that treatment issues are not necessarily a matter resolved by diagnosis. The aim in this dissertation is to set out an argument to that effect.

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Table of Contents

1. Introduction 6
2. Methodology and Terminology 11
2.1. Methodology 11
2.2. Terminological issues 12
2.3. Causes and causation 15
3. Conceptualising distressing psychological phenomena 17
3.1. Boundary of disorder and non-disorder 18
3.1.1. Wakefield's Harmful Dysfunction 20
3.1.2. Bolton's Critique 24
3.2. The Problem of group heterogeneity: Moving to a Complaint orientated approach 28
4. Treatment without disorder and the need to treat 33
4.1. Domain of psychiatric healthcare 35
4.2. The need to treat 39
4.3. The when question 44
4.4. The How Question 48
4.4.1. Mentalizing Based Therapy 52
4.4.2. Treatment and proximal causes. 61
4.4.3 Summary of the How Question 66
5. Concluding remarks 69
5.1. Limitations and criticisms 69
5.2. Conclusion 72
Bibliography 74

1. Introduction

Within the mental health profession there has long been a debate over how best to define the concept of mental disorder. More specifically, there is disagreement as to which criteria are best suited to demarcate the boundary between disorder and non-disorder. Each theorist has their own theory as to how best to define mental disorder. What drives this debate is more than simply philosophical interest. This debate is driven, in part, by important practical issues with potentially serious consequences, which *appear* to depend on where the boundary is drawn. To show that their own theory is better than alternative competing theories of mental disorder, authors describe how their own definition deals with these practical issues in a manner that minimises these serious harmful consequences.

One of the theorists involved in this debate is Derek Bolton. In his book '*What is Mental Disorder?: An essay in philosophy, science and values*' (2008), he explores some of the many challenges faced when defining the concept of mental disorder. Moreover, he discusses some of these practical problems that are *prima facie* resolved by providing a valid and reliable definition of mental disorder.

One of these problems, raised by Bolton, is the issue of the need to treat (Bolton, 2008). In short, practitioners require a means of knowing if a given patient requires treatment. As will be expanded below, Bolton (2008) points out that the need to treat issue is generally understood as being resolved by a diagnosis of a mental disorder. It is taken for granted that if a practitioner is to be able to reliably and effectively treat a patient they require a valid and reliable diagnosis of mental disorder. On the face of it then, the definition of mental disorder requires constant fine tuning.

In this dissertation it will be argued that at least one of the practical issues (the need to treat issue) that appears to require careful defining of mental disorder, in fact does not necessarily depend on a diagnosis of mental disorder at all.

While this may describe what is to be expected in this dissertation it does not do justice in describing the aim of this project. It might well seem inconsistent to raise the issue of the debate between theorists vying for the most apt definition of mental disorder, only to abandon the debate altogether and focus on the resolution of practical issues. However, the aim of this dissertation ought to be understood in the context of a larger overall philosophical position, regarding the necessity of a concept of mental disorder.

Through his book Bolton (2008) challenges the conventional notion of mental disorder as has been adopted by the medical model. He ultimately settles on either conceptualising the term mental disorder in terms of a 'harm only' criterion, or in favour of a more broad term, mental health problems, which may come with slightly less baggage (Bolton, 2008). Before doing so, and toward the end of his book he considers and ultimately rejects the possibility of abandoning the term mental disorder entirely (Bolton, 2008).

That said, abandoning the concept of mental disorder is not without its advocates. For example, Bentall (2003) argues that it is time to move away from a concept of mental disorder in favour or what he calls a Complaint-Oriented Approach. The general position that is endorsed in this dissertation is not that we ought to define mental disorder in a particular way, but rather that we ought to abandon the concept altogether[1].

It would, however, be a sign of grandiose delusions to think that a positive argument in favour of abandoning mental disorder could ever be achieved in a paper whose scale is so limited. To address the many problems that would be faced if mental disorder were

[1] This will be discussed below.

abandoned would require a project with a far larger scope than that which is afforded to this project.

As such, the scope of this paper is intentionally limited to a discussion around resolving 'the need to treat' issues. The focus is limited to this topic because it is generally accepted that this issue is indicative of the necessity for a robust definition of mental disorder. For any project which would make a positive argument in favour of abandoning the concept of mental disorder, the burden of proof is to show that treatment issues can be resolved, at the minimum, equally well without disorder. This is the aim of this dissertation.[2]

This dissertation is not making the positive claim that the concept of mental disorder should be abandoned. Rather, the aim is to address one potential criticism of a no-disorder account. The aim then is to take an arrow from the quiver of one who would argue that the concept of mental disorder is a necessary one for treatment reasons. It will be argued that the need to treat issue is not necessarily an issue of diagnosis, thereby bringing into question the necessity of the concept of mental disorder to decide on treatment issues.

Given the importance of this argument for a positive thesis that would advocate abandoning mental disorder, the positive claim requires some attention. In part this is because the necessity of the concept of mental disorder extends well beyond treatment issues. One might then question the importance of this dissertation from the start stating that it is not possible to abandon the concept, citing some of these other issues.

As such, some of the reasons sometimes given in favour of abandoning mental disorder will be discussed (albeit briefly) as well as briefly discussing just one example of alternate means of conceptualising these problems. In this paper the aim is not to provide a *complete* defence of abandoning mental disorder (or a similar concept) or diagnosis. Given the complexity of

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[2] Again while there are other supposed reasons in favour of the concept of mental disorder, these will not be dealt with in this paper. Each potential advantage would require lengthy in depth argument of its own.

that task and the limited scale of this project, justice could never be done to such a topic here. For this paper it will have to suffice to acknowledge the assumptions that underlie this project. That is that it is possible to imagine that other non-treatment related uses of the concept of mental disorder can be dealt with by a no-disorder account.

It is important to remember that it does not follow from the arguments set out below that there is no reason for a concept of mental disorder. Nonetheless, it does not mean that the issue at hand is unrelated. The arguments would be a necessary part of a larger argument that positively argues for abandoning mental disorder.

Section 2 below will note a brief methodological issue as well as some terminological ones. This is to ensure that there is no confusion as to the meaning of some of the terms that often have various specific theoretical uses/definitions and meanings.

Section 3 will be devoted to providing a brief discussion of the debate around the concept of mental disorder. The aim of this section is to provide some context to the purpose of the main arguments in section 4. It is not contended that it should follow from section 3 that one should abandon the concept of mental disorder. The aim is to give some good reasons one might make that positive argument. It will be argued that even though there are many other proposed advantages of mental disorder, there are many disadvantages. One example of how to eliminate the disadvantages through abandoning the concept of mental disorder will be briefly discussed. Moreover, the discussion of the debate between Wakefield and Bolton should serve to explain why Bolton's definition of mental disorder is used in section 4 rather than Wakefield's.

Section 4 forms the main body of this dissertation. It will be argued that, firstly the proper domain of psychiatric health care is not defined by the concept of mental disorder. Secondly it will be argued that knowing whether treatment is warranted or not depends on information

necessarily acquired by a practitioner prior to their ability to make a diagnosis. Thirdly it will be argued that knowing whether and how to treat depends not on diagnosis but on the knowledge of the pathways to symptoms and knowledge of how the proximal causes of those symptoms have their effect. An example of Metalizing Based Therapy will be made to illustrate this point. Finally section 5 will provide a brief summary and conclusion.

2. Methodology and Terminology

In this section, before undertaking the main body of work of this dissertation, it is necessary to start with a defence of the nature of the research as well as deal with a few terminological issues.

2.1. Methodology

The nature of the project in this case lends itself to *a priori* reasoning. The primary focus of this paper is to understand the necessary conditions for a practitioner to provide effective treatment. One might argue that we could interview mental health practitioners and question them about the process which they go through in determining and deciding on when and how to treat their patients. While this would indeed be interesting research and no doubt provide very interesting results, it would not serve the purposes of this dissertation.

Firstly, this would not tell us about the process that is *necessary* for a practitioner to answer the need to treat question. What it would speak to, is the process which practitioners *believe* that *they* use to conclude on need to treat issues. Secondly, this type of research would be limited by the clinical approach that is being used by the practitioner at the time of the study. This would not tell us anything of the necessity of the diagnosis of a mental disorder[3].

What are sought in this paper are the necessary conditions for a practitioner to decide on the need to treat issue. The emphasis then is on analysis of treatment and not what practitioners believe that they do to make those determinations on treatment. What we can do is look at

[3] In the remainder of this paper 'diagnosis of a mental disorder' will be shortened to 'diagnosis'. Diagnosis of a problem more generally would of course be important for treatment. The claim is that diagnosis of a *mental disorder* is not necessary.

how the information that is available to a practitioner, can provide information that is necessary to answer need to treat questions.

What is being inspected in this dissertation is an issue of knowledge. It is a question of what knowledge (of the practitioner) is necessary in order for them to make determinations as to how and when to treat. Discovering what they know before they answer need to treat questions tells us nothing of what knowledge is necessary. As such this type of project lends itself to philosophical enquiry rather than empirical research.

2.2. Terminological issues

As this dissertation progresses it might strike a reader that there an inconsistency with the terminology used in this paper and the proposed abandonment of conceptualising in terms of this type of terminology. In particular, were the concept of mental disorder to be abandoned altogether, other concepts and terminology that come with the medical model would also need to be revisited.

It might seem odd then that throughout the dissertation reference will be made to the necessary conditions for, of all things, *treatment*. At worst this might seem misguided and at best disingenuous. However there are two reasons why this dissertation retains some of the terminology from the current medical model. Firstly the terms are retained in part as a way of speaking to the issue from within the paradigm itself. What will be argued below is that in the present system of mental disorder and diagnosis, neither the concept of mental disorder nor a diagnosis of a specific disorder to which the individual belongs is necessary for one to provide effective treatment.

Secondly, making an attempt to provide definitions for a more consistent terminology would be well beyond the scope of this paper. Bolton's (2008) book devotes several chapters to discussing how best to alter the current terms to make them more in line with his theory. It is admitted here that this is important. However, this short dissertation cannot be devoted to dealing with this immense task. It might just as easily be some other term such as mental health care, which is often used interchangeably with treatment.

Throughout the paper there will be reference to treatment or health care or some other term denoting a similar concept, as well as the necessity of that treatment. For the purposes of this paper this should be understood broadly as intervention. This is not to say that the treatment or intervention refers only to active treatments. It is accepted here and argued in more detail in subsequent sections that the nature of intervention may be to do nothing. Treatment and intervention are simply shorthand for denoting that there is a selected course of action made by the treating practitioner. Where the dissertation refers to 'treatment' it might just as easily be read as saying, 'a given mode of intervention'.

The same is true for the term patient. Patient as used below is used as a means of referring to the individual who requires psychological intervention. It could simply refer to any person who is in psychological distress and arrives at the office of a practitioner. In no way should the words treatment or patient be understood as an endorsement of that term. Simply it should be understood as a convenient communication device. The same should hold true for any similar medical terminology whose use should not be seen as an endorsement of that term. On the contrary it is more likely that abandoning much of the medical terminology would be necessary if the concept of mental disorder were abandoned.

Furthermore, in this dissertation the term psychological/mental phenomena are employed often. These are used as blanket terms for a wide range of psychological experiences. For

example it will be taken that a euthymic mood and a depressed mood are psychological or mental phenomena. It is a term employed to cover cognitions, perceptions, moods or any other psychological states (or combination thereof) that are commonly dealt with by psychiatry and/or psychology. The sorts of states that tend to be the target of psychiatry and/or psychology will generally be referred to as *distressing* psychological states or phenomena.

One might be concerned that *distressing psychological phenomena* might not cover what are currently understood as ego-syntonic and ego-dystonic disorders. One might be concerned that there are many examples of people who can be diagnosed as having a mental disorder but are not in distress. It might be more appropriate to avoid distress and use the word harmful instead. This would work equally well. In this paper 'distressing' is favoured because it emphasises the causal role of the psychological phenomena in distress. Distress can then be broadly understood as extending beyond the individual.

2.3. Causes and causation

In the subsequent sections much will be made of causes of psychological phenomena. Moreover it will be argued that treatment turns on an understanding as to the causes of both distressing psychological phenomena as well as causal pathways out of such distress. As such it is contended that treatment is not an issue which depends on diagnosis of a disorder but rather the knowledge of the causes of psychological phenomena.

One worry might be that psychology and psychiatry are not actually worried about the ultimate causes of distressing psychological phenomena simply because we can only speculate (at least at present) about what the ultimate causes are. It might be contended that the causes in terms of aetiology are not what guide treatment at all.

For the purposes of this paper it will be accepted that perhaps this is true to some degree[4]. However, these ultimate causes are not the focus in this paper apart from one caveat. In the following section, an approach to conceptualising and understanding distressing psychological phenomena will be discussed which does indeed argue that research ought to look for primary causes. However, this is a matter for research and epidemiology and perhaps communication and not necessarily what treatment is about.

For the arguments in this paper it will be argued that treatment relies on knowledge of proximal causes. These causes need not be aetiologically primary. This is in part because to work out what the ultimate cause/s of a given psychological phenomenon is, is a remarkably complex task. Rutter (1997) argues that, neither the genetic factors alone, nor the environmental factors alone provide an explanation, as to why a particular person exhibits a particular trait or disorder.

Like Rutter (1997) this paper accepts that there are multiple causal factors and multiple pathways through which they operate that need to be understood in terms of the aetiology of

[4] Perhaps genetic treatments might be of interest.

any particular psychological phenomenon. What will be shown below is that there are particular causal processes that result in distressing psychological phenomena. The fact that these processes are in operation is what is of interest for the purposes of treatment and not the original cause of their activation. For the purposes of the arguments below, what will be argued is that deciding on what type of treatment is best depends on knowing which processes give rise to a particular distressing psychological phenomena and not necessarily what causes those processes to activate. These directly efficacious mechanisms will be referred to as proximal causes.

This might be better understood in terms of an example of a person who has a depressed mood. If a person has a depressed mood caused by an underlying medical condition, the treatment would take on a medical form. However, unlike in the medical case, we might know for the sake of argument that the person was disposed to depressed moods because of a particular environment-genetic interaction in early childhood. However it will be understood that *because* of those factors certain serotonergic processes or systems are affected, and it is through the operation of those systems that the mood is depressed. Aetiologically, there may be medical or environmental or genetic causes of the depressed psychological phenomenon but its expression in terms of the functioning of the serotonergic pathways would be the proximal cause.

3. Conceptualising distressing psychological phenomena

In the introduction of this dissertation it was acknowledged that this project might be considered as forming one part of a much larger thesis which favours discarding the concept of mental disorder. The goal in this dissertation is only to argue that answering need to treat questions does not depend on the concept of mental disorder. This is a trivial point without, at the very least, a brief explanation as to why abandoning mental disorder is favoured as well as what should replace it. Indeed it is often accepted that there are many other benefits of the concept of mental disorder. This section will be used to show that it is, at the very least, conceptually possible to imagine jettisoning the term.

In the first part of this section some brief defence of abandoning the concept of mental disorder will be offered. The focus will be on the debate between natural dysfunction accounts such as the one espoused by Wakefield (1992a) and the Non-naturalist account by Bolton (2008). The aim is not to provide a complete defence of abandoning disorder. Rather, the argument that treatment is possible without a concept of disorder is relevant in the context of the abandonment of the concept. To that end, some of the reasons for moving away from mental disorder will be outlined here. For this it will be argued that, as Bolton points out, an objective and non-arbitrary definition of mental disorder is not possible. The consequence of retaining an objective criterion then is poor reliability and validity. Moreover, Bolton's Non-naturalist account is endorsed in this paper. In section 4 it will be argued that mental disorder is not necessary to resolve treatment questions, and Bolton's definition of mental disorder will be used to do so.

In the second part of this section an alternate way of conceptualising distressing psychological phenomena will be briefly discussed. Again, this will serve less as a defence of a no-disorder position and more as an acknowledgment of certain underlying assumptions as to how distressing psychological assumptions ought to be conceptualised. If indeed this project falls within a larger philosophical argument for abandoning mental disorder, it is

necessary to explain how distressing psychological phenomena should be conceptualised if not as disordered. Furthermore it will expand on some of the problems with a concept of mental disorder which do not appear to be problems for no-disorder approaches.

The approach that is endorsed in this paper is an approach which has been referred to by Bentall (2005) as a 'complaint oriented' approach (COA).There is no moret time in this paper to discuss in any great detail the specifics of this approach nor indeed competing no-disorder accounts such as dimensional approaches. Instead, this section will point to arguments for why mental disorder is a poor way of conceptualising distressing psychological phenomena as well as a cursory overview of the COA.

3.1. Boundary of disorder and non-disorder

The concept of mental disorder intends to discriminate between the disordered and the non-disordered. According to this way of thinking, those who are disordered can be differentiated from those who are not. Moreover, the hope is to find a definition of mental disorder such that discerning the disordered from the non-disordered is an objective matter. The problem that will become clear here is that any attempt at providing a definition of mental disorder that objectively delineates the disordered from the non-disordered, falls short.

There are two authors that will be considered. To begin with, Wakefield's (1992a) definition of mental disorder as harmful dysfunction will be considered. He believes that including an objective component in the definition of mental disorder is necessary to distinguish disorder from non-disorder thereby safeguarding against over-pathologising (Wakefield *et al.,* 2005)[5]. In the first part of this section, Wakefield's account of mental disorder as harmful

[5] Over-pathologising arises from an incorrect definition of mental disorder as will be discussed below.

dysfunction, as well as how he and some of his co-authors believe dysfunction prevents over-pathologising will be outlined (Wakefield 1992a, 1992b; Wakefield *et al.,* 2005). In the second part of this section some of the objections posed by Bolton (2008) will be outlined. He contends that it is not possible to define mental disorder in any objective and non-arbitrary way[6].

It is the position of this paper that Bolton's objections are enough to show that Wakefield's naturalist account of mental disorder is not a useful way of conceptualising mental disorder. In particular, there is no room to think that we can, with any reliability or validity, regard psychological states as functional or dysfunctional. Moreover, without a non-arbitrary and objective definition, validity and reliability will always be an issue. Even Bolton (2008) acknowledges that this is a serious consequence for any definition of mental disorder, even his own.

3.1.1. Wakefield's Harmful Dysfunction

In an attempt to define mental disorder Wakefield (1992a, 1992b) proposes the *harmful dysfunction* criteria. For Wakefield there are two necessary criteria that need to be met before

[6] I will take it for granted that given the requirements of validity and reliability any subjective or arbitrary definition of mental disorder would simply not be good enough.

one can make a diagnosis of a mental disorder. Firstly there must be an evolutionary dysfunction. This is to say that in a disordered state a mechanism functions in a way other than the way that it was 'designed to' by evolution. Secondly this dysfunction results in harm to the individual.

For example, the phenomenon of anxiety can be said to have evolutionary function. Anxiety improves survival in dangerous situations by increasing blood flow, increasing adrenalin as well as many other functions, all of which improve chances of survival in the face of a physical threat. On Wakefield's account, anxiety as a mental disorder mental disorder is when an individual is anxious and there is no real threat to their life, the anxiety is dysfunctional. If the anxiety in that case also results in harm, then one could find that the person suffers mental disorder (provided of course that all the necessary criteria have been met).

However, there are many different ways to understand function and dysfunction. Wakefield (1992a) understands function in terms of the role that a particular mechanism evolved to fulfil. For example the nose evolved to fulfil many functions. It is essential for breathing and filtering harmful bodies before air reaches the lung (Wakefield, 1992b). However, it was not designed (through evolution) to hold up spectacles. As such we would consider a nose to be dysfunctional if it could not be used for breathing, or allowed too many pathogens into the lungs (Wakefield, 1992b). However the fact that a person's nose does not hold up their spectacles would not render the nose dysfunctional. That would merely be a nuisance (Wakefield, 1992b).

To understand dysfunction as Wakefield has, we need to understand what it means for a mechanism to function.

> “Natural mechanisms, like artifacts, can be partially explained by referring to their effects, and natural functions, like artifact functions, are those effects that enter into such explanations” (Wakefield, 1992a p.382)

He goes on to say;

> “…the heart's effect of pumping the blood is also part of the heart's explanation, in that one can legitimately answer a question such as "Why do we have hearts?" or "Why do hearts exist?" with "Because hearts pump the blood." The effect of pumping the blood also enters into explanations of the detailed structure and activity of the heart. Thus, pumping the blood is a natural function of the heart… A natural function of an organ or other mechanism is an effect of the organ or mechanism that enters into an explanation of the existence, structure, or activity of the organ or mechanism.” (Wakefield, 1992a p.382)

This type of design is what Bolton (2008) calls teleological or naturalistic function. It is the hallmark of Wakefield’s naturalistic account of mental disorder. By contrast, “…dysfunction is the failure of a mechanism to perform its natural function” (Wakefield, 1992a p.383)

The second criterion is that there must be harm. The harm criterion along with the dysfunction criterion safeguard against the use of ‘mental disorder’ as means of social control (Wakefield, 1992a). For instance homosexuality might be seen as contrary to the natural function of sexuality which might be considered procreation. However if there is no distress or harm then no diagnosis should be made (Wakefield, 1992a). The harm criterion respects the autonomy of the individual. It allows for objective dysfunction without any harm. So we cannot diagnose someone with a mental disorder in the absence of harm.

To safeguard against social control and overpathologising, Wakefield requires both objective facts and social values. Neither harm alone nor dysfunction alone is sufficient for mental disorder but both are necessary. This protects against the diagnosis of individuals who, it might be argued, have some dysfunctional psychological mechanism but experience no harm,

as well as cases where there is harm but that harm is expected in such a circumstance. Wakefield (1992a) would find homosexuality an example of the former and bereavement as an example of the latter.

For Wakefield then, the harmful dysfunction definition of mental disorder provides an objective and non-arbitrary boundary between disorder and non-disorder. The need for this goes beyond academic purposes however. Wakefield *et al*. (2005) argue that the dysfunction criterion is understood as coming from this evolutionary perspective, safeguards against over-pathologising. In fact this is one of the primary reasons for the inclusion of dysfunction in the criteria. The reason behind its inclusion is as that if we have an objective criterion that needs to be met in order that a practitioner makes the diagnosis of a mental disorder then it eliminates room for human error or social control. For Wakefield *et al,* (2005) the validity and reliability of a diagnosis is only made possible by referring to the objective notion of evolutionary dysfunction.

In the paper Wakefield *et al*. (2005) argue that some normal phenomena such as social anxiety are over-pathologised. They argue that social anxiety is a normal state which is designed to prevent an individual from acting in a way that would compromise their position in their social circle. They argue that if we take seriously a teleological/evolutionary stance toward dysfunction we can see that there are far more normal instances of social anxiety. Without this reading of dysfunction, we risk diagnosing and treating many people who are distressed by their appropriate social anxiety (Wakefield *et al*, 2005).

The point is that the finding of an evolutionary dysfunction prevents diagnosis and treatment of normal or expected distressing psychological/mental phenomena. This is a position that is endorsed by many authors who believe that there are normal or expected distressing psychological phenomena. For example it has been suggested that sadness has become

pathologised by diagnostic manuals (Horwitz & Wakefield, 2007). They argue that sadness is an expected human phenomenon (Horwitz & Wakefield, 2007). The point is that if we understand why sadness is functional we are less likely to over-pathologise and treat those who ought to be expected to be sad (Horwitz & Wakefield, 2007).

The answer to over-pathologising then is seen to be the inclusion of an objective criterion. It is argued by Horwitz and Wakefield (2007), and Wakefield *et al* (2005) that this objective criterion ought to be evolutionary dysfunction. [7]

Of course the reverse is equally true, albeit for a slightly different reason. The harm criterion safeguards against the use of 'mental disorder' as means of social control (Wakefield, 1992a). For instance homosexuality defies the natural function of sexuality which might be considered procreation. However if there is no distress or harm then we ought not to diagnose (Wakefield, 1992a).[8] The harm criterion respects the autonomy of the individual. It allows dysfunction without any harm. So we cannot diagnose someone with a mental disorder in the absence of distress or more broadly harm.

Led by Wakefield there is a large body of literature which suggests that the best way to answer questions around when to diagnose and of course intervene is with the inclusion of an objective criterion. For Wakefield that criterion is an evolutionary conception of function and dysfunction. Importantly for the purposes of this paper, Wakefield's definition of mental disorder requires that there be some objective criterion which guides practitioners in determining the merits of diagnosis and treatment. [9]

[7] Lane (2006) points out that in order to raise the threshold for diagnosis of mental disorder, the taskforce for the DSM-III actually did the opposite. Of course the DSM-IV definition remained more or less the same as that of the DSM –III. What is said to be missing is the inclusion of a concept of dysfunction that is proposed by Wakefield.

[8] However one might find ego dystonic homosexuality. Of course ultimately it boils down to what the function of sexuality is. It might not be the case that homosexuality is dysfunctional at all. This is one line of reasoning as to why homosexuality is not considered a mental disorder.

3.1.2. Bolton's Critique

Wakefield's account is not without its critics. One such critic is Bolton. In his book "What is mental Disorder" (2008) he argues that there is no place in a definition of mental disorder for the teleological conception of function that is proposed by Wakefield. He claims toward the end of his book that it might be worth considering abandoning the concept of mental disorder (Bolton, 2008). Instead, owing to the challenges of jettisoning the term, he favours a harm only definition of mental disorder (Bolton, 2008). In this section two of the arguments levelled at Wakefield's evolutionary dysfunction criterion will be outlined.

What then are Bolton's objections to Wakefield's account?

Bolton (2008) argues that evolutionary dysfunction as Wakefield proposes cannot be a demarcation criterion of mental disorder at all. To do so he argues that Wakefield mistakenly separates evolutionary function from its social context. Of course adaption is always context bound. But, this is not what Wakefield says. In fact he commits himself to a very narrow meaning of dysfunction that excludes the context. In the previous section it was argued (as Bolton does) that for Wakefield dysfunction refers only to its natural function or that which it was designed through evolution to do. Dysfunction is the failure to do what it was designed to do. This excludes context and deviation from statistical norms. Hypothetically, many people could suffer some change to a major organ that would render it naturally dysfunctional, but the fact that it would be statistically normal to have an organ working in that way would not make it functional.

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[9] One of the advantages of a no-disorder position such as the complaint-oriented approach discussed below is that it stays true to the spirit of Wakefield by proposing that treatment is guided by objectively knowable causal mechanisms of psychological phenomenon without some of the problems.

Moreover, Bolton (2008) points out that in a paper defending dysfunction as a value-free concept Wakefield himself shows that dysfunction relies on a statistical use of dysfunction rather than a naturalistic one. Referring to whether or not the a child's separation anxiety qualifies as dysfunctional or not Wakefield argues that " …they could be considered to be responding with proportional, normal range separation responses to a highly unusual environment in which an extraordinary kind of separation anxiety was taking place…" (Wakefield 2002, p 158)

The concept of natural dysfunction, as Wakefield uses it, is a statistical notion of dysfunction and not based on its evolutionarily explained function. Not only does understanding of the child's dysfunction rely on a context or expectation as to whether it is appropriate but also a statistical criterion of what is to be expected by others in a similar population.

While Wakefield argues many times that his conception of dysfunction is not a value concept, Bolton correctly emphasises how the only way to understand evolutionary dysfunction is to include in it both a context and a comparison to similar population groups. As such it could never be the objective criterion required by Wakefield. Bolton (2008) argues that while Wakefield's account aims at isolating natural dysfunction from the social context, he ultimately fails.

One further argument highlighted by Bolton (2008) is that there are many different ways of understanding the evolutionary origin of a particular mechanism. He argues that if we adopt an evolutionary or natural understanding of dysfunction, we ultimately end up speculating as to the original purpose of a mechanism (Bolton, 2008). As he points out, even the best hypotheses as to the purpose to which a mechanism was originally set has many competitors that seem equally capable of explaining the presence of a particular mechanism or trait (Bolton, 2008).

Bolton (2008) argues that this has serious implications for reliability and validity. If we can have no certainty as to the original purpose of a psychological mechanism then how can a diagnosis of mental disorder be reliably made (at least if evolutionary function is that criterion)? Moreover given that there is such a high degree of speculation involved, how could a practitioner reliably use the concept of mental disorder?

For these and many other reasons Bolton (2008) favours a harm only conceptualisation of mental disorder. Moreover, he considers abandoning the term mental disorder or at least the use of a less loaded term such as *mental health problems*, to describe the conditions that are described in manuals.

Unlike Bolton who argues in favour of redefining mental disorder, however, it is the position of this dissertation that the term mental disorder ought to be abandoned altogether. Nevertheless, even if the harm only definition of mental disorder were adopted, the conceptual problems in the following section would still apply.

Bolton's conception of mental disorder is mirrored in some ways in the DSM 5. Consider the definition of mental disorder provided in the DSM 5. Below is the DSM 5 definition.

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

The above is not at definition that clearly identifies or endorses an evolutionary concept of dysfunction.

The aim of this section was not to provide detailed arguments as to why mental disorder is not necessary. Rather it was to show that it is not necessarily clear how to provide an objective, valid and reliable account of the concept of mental disorder. In the following section an alternate view will be described that would not suffer the same problems, but would none the less maintain some of the objectivity of Wakefield's account without its drawbacks.

3.2. The Problem of group heterogeneity: Moving to a Complaint orientated approach

Defining mental disorder poses other remarkably difficult challenges[10]. The first challenge is that those who are diagnosed with the same disorder can be completely dissimilar which in itself raises questions of reliability and validity of mental disorder. To understand why this problem arises, it is necessary to first look at the origins of the concept. Mental disorder is a term that was initially adopted from the medical model initially by Kraepelin (Bentall, 2005). The model adopted by Kraepelin;

> "…assumes that the severe mental illnesses fall into discrete types such as 'schizophrenia' and 'manic depression', and that there is a clear dividing line between madness and normal functioning" (Bentall, 2005. p.220).

This approach gave rise to the current paradigm of mental disorder. As in medicine, it was assumed that problems presented with discrete clusters of regularly occurring symptoms. (Murphy, 2015). Each of these clusters of regularly occurring symptoms represented a specific mental disorder.

This way of conceptualising distressing psychological phenomena was broadly accepted and over time became the system used today (Murphy, 2015; Bentall, 2005). However Kraepelin's adoption of the medical approach was not as a result of his belief that it accurately represented psychological phenomena (Bentall, 2005). Rather, given the limited understanding of the complex processes that give rise to distressing psychological phenomena, Kraepelin believed that this type of approach was only to be used as a starting off point (Murphy, 2015). Murphy argues that;

> "[k]raepelin's preferred basis for classification and inquiry actually rested on his less well-remembered belief that "pathological anatomy promises to provide the safest foundation" for classification of mental illness in a mature psychiatry (1899, 2). He considered the correct taxonomy would be one in which

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[10] There are many critics of mental disorder who provide detailed arguments as to the problems that are associated with such a categorical concept. For a detailed summary of these arguments Murphy (2015) provides a thorough review of these arguments.

> clinical description, etiology and pathophysiology coincided: "cases arising from the same causes would always have to present the same symptoms and the same post-mortem result" (3)." (Murphy, 2015)

It was clear to Kraepelin that the presentation of two seemingly similar cases might have entirely different causal pathways. With limited information regarding causal mechanism and physiology, Kraepelin's view was that categorisation into apparently regularly occurring clusters of symptoms would provide a useful starting point (Murphy, 2015). He believed that there would be greater value in the investigation of specific processes and aetiology of the psychological symptoms (Murphy, 2015).

With more information available it is possible to see that Kraepelin has a strong case. Bentall (2005) points out that two individuals with a diagnosis of schizophrenia may well have entirely different symptoms (Bentall, 2005). All those who are diagnosed with Schizophrenia do not form a neat homogeneous group, at least in terms of symptoms. For example the symptom of disorganised speech may be present but without auditory hallucinations (and *vice versa*).

However, the mechanisms responsible for hallucinations (particularly auditory ones) are probably different from the mechanisms resulting in delusions or disorganised speech (Bentall, 2005)[11]. None the less, two individuals who meet criteria for the same disorder then can have very few symptoms in common. As such the diagnosis of schizophrenia does little to describe the problems or the individual to whom the diagnosis applies (Bentall, 2005).

[11] For greater detail regarding the specific aetiology regarding these symptoms Bentall (2005) provides a short summary, or his 2003 book 'Madness explained' offers a more complete account of psychotic pathways (Bentall, 2003). For the purposes of this paper it will have to suffice to simply admit to the assumptions behind the arguments put forward.

Ultimately, the members of the set who fall under the category of a given disorder may have entirely different symptoms which are in turn caused by different and potentially even unrelated causes. This has implications for research and treatment (Bentall, 2005).

A second problem that arises is that, according to the neo-Kraepelinian approach ,symptoms are clustered in discrete categories which rule out the possibility of overlapping categories (Bentall, 2005). There should be clear boundaries between disorders[12]. Instead there is a blurring of boundaries between disorders such as schizophrenia and mood disorders which results in the creation of an overlapping disorder of schizoaffective disorder (Bentall, 2005). Disorders fade into one another with varying combinations for symptoms.

On its own, this is not an indictment of the concept of mental disorder. The problem is that as soon as it is accepted that there are many combinations of symptoms that do not conform to regularly occurring clusters, the validity and reliability of diagnosis is called into question (Bentall, 2005). The net result is that firstly, there are an ever increasing number of disorders (as in the case of Schizoaffective Disorder) that are designed to cover the continuum of certain symptoms. Of course, each newly created category suffers the same problem that spurred its own creation. The problem is that there is no clear way of distinguishing between cases at the borderlines.[13] This does not solve the problem. It merely shifts it.

Secondly, there must be the creation of "other specific disorders" (as is the case with the DSM 5) designed to account for cases where symptoms do not conform to an accepted category. Of course this has direct implications for research. The members of the set who are diagnosed in this way will still have a wide range of symptoms that are unrelated. As it was

[12] As well as between disordered and non-disordered. Arguments to the effect that there are no clear, non-arbitrary way of discriminating between normality and abnormality were in the previous section

[13] Again Wakefield's evolutionary dysfunction could not do this without any speculation.

with schizophrenia above, the individuals with this diagnosis might have a wide range of problems, each of which needs to be researched and treated differently.

Bentall (2003) argues that it would be better to move away from the notion that there are discrete clusters of regularly occurring symptoms and favour a more detailed approach. It is his position that we abandon diagnosis of mental disorder altogether. Instead he favours the COA to psychological phenomena. In this approach each case is to be understood in terms of the specific processes that result in the actual behaviours, cognitions and experiences of people. In short this account favours zooming in on causes of the particular complaint (Murphy, 2015).

Conceptualising psychological phenomena in terms of their causal processes and pathways is an approach advocated by Bentall (2003, 2005). His COA or symptom-oriented approach, takes it that the best way to formulate distressing psychological phenomena is to focus not on the cluster of symptoms but the pathways to the symptoms that are present (Bentall, 2005). Moreover, on this approach there is not necessarily a need to distinguish between normality and abnormality. Pathways function as they function and normative questions as to their normality need never arise. This sort of approach then can avoid getting into the same problems as the mental disorder approach in which validity and reliability are called into question as a direct consequence of trying to demarcate the normal/abnormal boundary. [14]

Of course this approach may offer an alternate way of researching and understanding psychological phenomena but as Bentall himself points out, there are some questions as to whether this type of formulation will benefit the patients (Bentall, 2005). It is here that aim of

[14] Of course one might contend that there are many competing theories as to the proximal causes of any psychological phenomena. This might make the process seem speculative. Of course it is speculative in the same sort of way that it is at present. There are many theories as to the pathways and the process of testing the validity reliability and effectiveness of each is the process scientific research. In terms of treatment, as more pathways are verified as being effective the treatments become less speculative. Of course this is not only a problem for the COA but for the scientific research of treatment in general.

this dissertation finds its place. Below it will be argued that treatment is possible without disorder. Moreover, one of the interesting features of the arguments below might be that (in fact) what makes treatment possible and effective is this sort of zooming in and focusing on specific causal factors (not necessarily primary causes). Improved understanding of these causal pathways may improve the quality of treatment.

While this does not serve as a complete justification for adopting the complaint oriented approach, it should at the very least serve to flag the assumptions that are implicit in this paper. The assumptions are firstly, that there are some reasons to be sceptical as to the necessity of the concept of mental disorder in so far as it neither demarcates the boundary of abnormality in any non-arbitrary fashion, nor are members of a given group homogenous with respect to their specific symptoms. Secondly, that adopting an approach such as the COA described above might yield greater understanding of distressing psychological phenomena and improve the validity and reliability of research more generally.

4. Treatment without disorder and the need to treat

It is time to begin looking at the main focus of this dissertation. Consider the following extract from the DSM 5 concerning the necessity of reliable diagnoses:

> "Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research." (American Psychiatric Association, 2013. p.5)

As we can see from the above quote, there are many reasons given as to the importance of reliable and valid diagnostic criteria. First stated among them is the implication diagnosis has on treatment[15]. It is not coincidence that in the introduction of the DSM 5 treatment is cited as an important consideration pertaining to diagnostic matters.

It is generally accepted that issues of treatment depend on the making of a diagnosis. Bolton (2008) points out that:

> "It has long been apparent that there is a close connection between making a diagnosis of illness or disorder and warranting clinical attention and treatment. Giving a diagnosis presupposes distress, impairment, or risk in a degree sufficient to indicate need for clinical care, and diagnosis is commonly required to access it." (Bolton, 2008, p. 190)

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[15] In the introduction to this dissertation reasons were outlined as to why some of the other advantages would not be dealt with here.

In fact it is not hard to find examples of treatment manuals that begin by describing the importance of diagnosis in treatment issues. For example, Nancy McWilliams (1994), coming from a psychoanalytic orientation, states that:

> "There are at least five interrelated advantages of the diagnostic enterprise when pursued sensitively and with adequate training: (1) It's utility for treatment planning, (2) it's implicit information about prognosis, (3) it's contribution to protecting consumers of mental health services, (4) it's value in enabling the therapist to communicate empathy, and (5) it's role in reducing the probability that certain easily frightened people will flee from treatment. In addition there are fringe benefits to the diagnostic process that directly facilitate therapy." (McWilliams, 1994, p.7)

Though this is just one example it is clear to see the assumption regarding the necessity of diagnosis when it comes to treatment issues. It is assumed that the making of the diagnosis plays a major role in what guides treatment.

Any approach to distressing psychological phenomena which advocates abandoning the concept of mental disorder and diagnosis would then seem to be at a disadvantage when it comes to its effectiveness at resolving treatment issues. There is a burden of proof that rests on one who argues for such a position to show that they are, at the very least, no worse at resolving treatment issues without a concept of mental disorder (the minimum requirement) and at best, able to show that they are better equipped to do so.

The claim that is being argued for in this dissertation is not that there is no such thing as mental disorder. Rather, it is that the concept of mental disorder is not necessary for the clinician to make important decisions regarding the treatment of a patient. While this project fits into an overarching position as to how best to conceptualise distressing psychological phenomena, it will not follow from the arguments in this section that the concept of mental disorder *should* be jettisoned. It only follows that it would be possible to do so without

compromising a practitioner's ability to decide on treatment issues (the minimum requirement).

The assumption that treatment issues depend on diagnosis will be challenged here. Firstly, it will be argued that psychiatric treatment does not exclusively treat disorders. On its own this will not be enough. Secondly, to bolster the argument it will be argued that even in cases where an individual would meet the criteria for a mental disorder, (1) knowing that treatment is warranted (when to treat) and, (2) knowing how best to treat (how to treat), both depend on the acquisition of information which is *necessarily* acquired temporally prior to the making of a diagnosis.

4.1. Domain of psychiatric healthcare

If we are interested in showing that treatment issues do not require diagnosis of a mental disorder then a good place to start is by showing that it is not the case that what is treated is disorders.

To begin this discussion it is first necessary to discuss how to define the proper domain of psychiatry. Bolton (2008) asks the question:

> "Is there a proper domain for psychiatry: treatment of mental disorder- or does it really and illegitimately just monitor and manage social deviance?" (Bolton, 2008, p. 193-194)

On the one hand it might be that the domain of psychiatry is limited by the nature of the specific types of problems (mental disorders). On the other hand the domain is limited by the type of work that is done by psychiatry. He argues that it is not the former and instead favours the latter.

Bolton (2008) argues that a parallel can be drawn between medicine and psychiatric treatment. In medicine for example, there are many instances when what is being treated is not a disorder (Bolton, 2008). What they treat is suffering (Bolton, 2008). Physicians are not required to draw a distinction between the normal and the abnormal or the disordered and the non-disordered[16] (Bolton, 2008). What they do is they use their judgment and experience to alleviate suffering.

A similar point is made by Horwitz (2007) in his discussion regarding overpathologising ordinary experiences. In this case, referring specifically to psychiatry, he states that:

> "… clinicians can ignore the official DSM criteria and substitute their own judgement when they decide they are dealing with conditions that are connected to social situations and are not mental disorders. Moreover, clinical treatment can sometimes relieve the distress of suffering people who might not have disorders, just as physicians often use anaesthesia to numb the normal pain that stems from childbirth." (Horwitz, 2007, p. 215-216)

Just like the physician who treats the normal labour pains of a mother, in psychiatric healthcare there are often times when intervention is required that does not aim at treating a disorder. Bolton (2008) points out that psychological problems that are either socially or environmentally imbedded exclude the diagnosis of a mental disorder.

For example, one might consider a woman who is depressed because of her poor socio-economic status (Bolton, 2008). Her depression is because of her low income and her poor housing (Bolton, 2008). This may be a remarkably distressing experience for her. However, they are the expectable results of her environment and therefore a diagnosis would be ruled out. Nevertheless some form of intervention can be and often is offered (Bolton, 2008).

[16] Even though they often do make judgments about disorder/normality questions.

A further example might be of an African-Caribbean boy excluded from school in the UK due to his unacceptable behaviour (Bolton, 2008). In the case that his behaviour is due to a culturally accepted standard of good behaviour, no diagnosis could be given. However, treatment might be offered in the form of helping the parents identify the behaviours that are causing the problems at school, and working towards finding a way to learn how to behave in the new context (Bolton, 2008).

These sorts of examples serve as counterexamples to a claim that the domain of psychiatric treatment is limited by the type of problem that is treated or a determination as to normal/abnormal/disordered/non-disordered.

Consider Bolton's question once again. He asks:

> "Is there a proper domain for psychiatry: treatment of mental disorder-or does it really and illegitimately just monitor and manage social deviance?" (Bolton, 2008, p. 193-194)

In some ways Bolton ultimately agrees with the latter. He argues that the domain is,

> "…defined by a distinctive kind of response to problems, rather than by a distinctive kind of problem." (Bolton, 2008, p. 194)

Later he states that:

> "The domain is not defined fundamentally within the nature of the problems themselves. Rather, the domain is the *response* to the conditions, the physician – patient, the professional healthcare relationship." (Bolton, 2008, p.195)

For Bolton, treatment in mental health matters goes beyond the treatment of only disorders. With the counterexamples above it is clear to see that certainly psychiatric treatment (broadly considered) is applied in many cases where there is no finding of mental disorder. These examples aside, there are a myriad of existential problems that are treated by the broad field

of psychiatry. Treatment is offered to those who are bereaved, or simply having an expectable though distressing psychological response to any number of ordinary human experiences.

Is this quite enough to show that it is possible to decide on treatment matters without a concept of mental disorder? Not quite. What this shows is simply that it is not always the case that what is being treated is a mental disorder. However, one might still wish to contend that in cases where it is possible to make a diagnosis of a mental disorder, the diagnosis is necessary to resolve a wide range of treatment issues. This is the sort of claim asserted is the extract from McWilliams (1994) in the introduction to this section.

What the argument above does serve as is an elucidation of how, hypothetically, psychiatric treatment does not necessarily always rely on a concept of mental disorder. What is needed in this dissertation is an argument to show that treatment issues are not resolved by diagnosis at all. In the remainder of this chapter, it will be argued that though it appears that these treatment issues are resolved by a diagnosis of mental disorder, a practitioner is able to resolve them with information that is necessarily acquired before the making of a diagnosis.

4.2. The need to treat

The treatment issues being addressed here can broadly be considered the "need to treat" issue (Bolton, 2008). Before moving on to the main arguments in this section the need to treat requires a brief discussion. What is the 'need to treat' issue? The need to treat issue is an issue of decision-making. Practitioners are required to make decisions around treatment each time a patient presents. It is these decisions regarding treatment that constitute the 'need to treat' issue.

In this dissertation the 'need to treat' issue will be dealt with as an issue of two parts. The first part is a question as to the conditions that necessitate treatment. A practitioner needs to be able to make a decision as to when treatment is warranted or not. In what follows, this will be referred to as the "when" question. The second part of the 'need to treat' issue is a question relating to the nature of, or mode of treatment that is to be selected by a practitioner. Once it has been determined that treatment is warranted or necessary, a practitioner is faced with a decision as to what mode of treatment will be most effective. In this paper this question will be referred to as the "how" question.

Strictly speaking, the two parts are not entirely separate. As will become clear later knowing how to treat sometimes means that the practitioner does nothing but wait. Equally, it is possible that we may know that treatment or intervention is warranted but have no way of treating a particular psychological phenomenon. However, knowing generally that treatment (or intervention) is warranted, is sufficiently dissimilar to knowing how best to treat so as to merit separate arguments.

To see thi0,s let us suppose for the time being that the ability to determine whether or not treatment is warranted does indeed depend on diagnosis of a mental disorder. Let us begin by considering how a practitioner would go about making a diagnosis at present. Accepting that

Bolton's critique of evolutionary dysfunction is correct, as was argued above, this requires a judgment as to the significance of the harm[17].

However, more is required if we are to make a diagnosis. Knowing that there is sufficiently significant harm only indicates the presence of some mental disorder generally speaking[18]. To finalise a specific diagnosis the practitioner must first identify the symptoms that manifest in a harmful manner. The presenting symptoms that comprise the set are compared to the sets of symptoms associated with specific mental disorders. If no exclusion criteria are met and the set of symptoms bears sufficient resemblance to one or more disorders, they are categorised as such.

This diagnostic process described above represents two separate processes. This is because the content that the practitioner is required to evaluate, though related is different. On the one hand the practitioner is required to make a judgment about the severity of the harm. The question that is asked is whether these symptoms represent sufficiently significant harm for diagnosis of a mental disorder[19]. The second process is not a qualitative evaluation of the symptoms, but rather a quantitative one. The question is not how the symptoms are experienced, but rather an observation as to the quantity and their relationship to the set.

Evidence that they represent distinct processes can be found in the DSM 5 itself. The DSM 5 makes use of the term "unspecified disorders" and "other specific disorder". The latter of these two is used when there is clinically significant distress[20]. However, though the presentation closely resemles an existing disorder, it cannot be categorised as such because

[17] Remember that Bolton's definition of harm is broad enough to include both ego-syntonic and ego-dystonic disorders (Bolton, 2008).
[18] I am excluding cases of environmental harm, but these are equally identified in the absence of a diagnosis of a mental disorder.
[19] Of course this in itself is vague and should be considered a reason to be sceptical of the concept of mental disorder. This is not only a part of Bolton's definition of mental disorder but equally it is found in the DSM 5 and even Wakefield who acknowledges the subjectivity of this criterion.
[20] Of course for Bolton this is depends on clinical judgment. I will not go into the problems with assessing the criterion in this way.

one or more symptoms are missing. If the clinician chooses to specify the symptoms that are missing the diagnosis will include “other specific disorder”. However, should the clinician not specify the reason the diagnosis will include the term “unspecified”. More specifically: “When the clinician is *not able to further specify and describe the clinical presentation*, the unspecified diagnosis can be given.”(American Psychiatric Association, 2013. p. 16) (my emphasis added).

As such, the DSM 5 recognises that there are occasions where there is need for diagnosis due to the significance of the harm, but there is either not enough evidence of the symptoms that are present or that the symptoms represent some other potential disorder that is not described by the manual. If we can make a diagnosis of mental disorder *generally* without the ability to make a diagnosing a *specific* mental disorder, then they must represent distinct processes.

The two separate processes described above provide information as to the qualitative experience and the quantitative symptoms. The former refering to diagnosis *generally* in which all that is required is the evaluation of harm, while the latter to *specific* diagnosis which requires knowledge of the symptoms. Indeed we can know each of them individually, without knowing the other.

If the assumption that treatment issues are a diagnostic matter were true, knowing when to treat would depend on the presence of a diagnosis of a general disorder. Knowing how to treat would likely depend on the nature of the specific disorder. When we look at the need to treat issue in this way, it is possible to see that we can know when to intervene without knowing exactly how best to do so and *vice versa*. As such the need to treat represents two separate questions, the when question and the how question.

That said, what can be said about the need to treat issue? In his book Bolton (2008) argues that when it comes to the need to treat issue, nothing is lost in the redefining of mental

disorder as a strictly non-naturalist concept. As discussed above, his non-naturalist account retains the concept of mental disorder as a harm only concept.

In the event that the need to treat issue is a diagnostic issue, then on his account, deciding if treatment is warranted depends on a diagnosis, which is settled by evaluating harm. Moreover, he argued that the need to treat issues are matters to be resolved by an evaluation of harm or risk thereof. He states that :

> "... it should be said that the 'need to treat' is to be understood in this context in a broad sense. It may include the recommendation of an active treatment intervention such as medication or psychotherapy but it includes professional monitoring of the course of presenting problems that do not as yet require active interventions, either because the problem may be self-limiting and there is scope for spontaneous recovery in the foreseeable future or because no harms have yet accrued. The monitoring, sometimes called watchful waiting, may lead to no active intervention, if spontaneous recovery does occur, or to active treatment if the problem becomes chronic and associated with significant harm or risk of harm." (Bolton, 2008, p189)

In the above extract we can see that the commencement of treatment *and* the type of treatment that is required depends on the consequences of the particular psychological phenomenon[21]. In cases where there is as yet no harm or the harm is likely to dissipate on its own without intervention, we do not have any need to treat. On the other hand if there is significant harm or at least a risk of harm we would commence treatment. Ultimately, determining whether treatment is warranted or not, as well as the nature of treatment (in part) depends on the harm associated with a particular psychological phenomenon. [22]

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[21] Unlike in this dissertation, Bolton treats both the when and how components of the need to treat issue as if they are one issue. He does this in part because it is sufficient for him to simply point out that his non-naturalist definition is not missing anything that would be used to resolve the need to treat issue. Specifically, evolutionary dysfunction does not feature in deciding when or how to treat.

[22] One might contend that Wakefield's account would suggest that evolutionary dysfunction plays a role. However, it seems clear that it is not possible to retain an evolutionary account of dysfunction as was argued above. For these purposes Bolton's account is sufficient to show that at least in the case of deciding when to treat, an evaluation of harm is all that is necessary.

This argument is used to highlight the importance of harm. Specifically, there is no need for dysfunction at all in the need to treat issue, as the questions that arise are best answered by assessing the harm. The argument might be put as follows: If the need to treat does depend on diagnosis and the need to treat is resolved by assessing only harm (and the nature of the harm), then a harm only definition of disorder is sufficient to resolve need to treat issues.

Bolton's discussion of the problem does not automatically settle the matter as to the necessity of a diagnosis for need to treat issues. It still might be that in cases where a diagnosis would be made, the diagnosis is what settles the need to treat issue. Nevertheless, his arguments are essential to the arguments here. The significant insight that comes from Bolton is that deciding when to treat is a question that turns on an evaluation of harm. How then can need to treat issues be resolved in the absence of a concept of mental disorder?

4.3. The when question

While Bolton's discussion of the need to treat was necessary to show that nothing is lost in the redefining of mental disorder as a strictly non-naturalist concept, the task here is somewhat more complicated. For the overarching project endorsing abandoning mental disorder, the burden of proof here is to show not only that nothing is lost without dysfunction, but that nothing is lost if we abandon the concept of mental disorder altogether. In the context of this dissertation the aim is to show that the need to treat issues can be resolved without a concept of mental disorder.

Previous sections outlined Bolton's claim that on a non-naturalist account of mental disorder, both diagnosis of mental disorder and resolving need to treat issues depend on an assessment of harm. If we then abandon the concept of mental disorder, how then do we decide when to treat? This "when" question will be the focus of this section.

How is it possible that the information necessary to answer the when question is necessarily acquired prior to the making of a diagnosis? For this we need to show that each of the crucial diagnostic processes as well as the sorts of information necessary to determine that treatment is warranted. Consider the following hypothetical example of Mrs X.

> Mrs X made an appointment to see a psychologist .She arrives at the psychologists' office for her first appointment. She reports to the psychologist that she has been feeling sad for several months. It has impacted on her ability to successfully complete her work assignments because she can barely get out of bed most days. When she does manage, she finds herself too tired to concentrate. Because of this she has received a warning from her employer that should she continue to fail to meet deadlines and complete assignments she will likely be fired. This has made her question whether life is worth living and has attempted to kill herself on two occasions. The excessive amount of sleep she gets at night has stopped her from seeing her friends, which she feels is a good thing because she is not in the mood to see them anyway.

If we look at the case of Mrs X it is easy to play diagnostician and evaluate symptoms and diagnose her as perhaps suffering from Major Depressive Disorder. What is required for that is both the qualitative and quantitative diagnostic process described earlier. For now however let us look at what is necessary to answer the when question. We notice that what is required for this is only the qualitative process which on its own cannot result in the making of a specific diagnosis of mental disorder.

On Bolton's account which is accepted as the best viable option, what is necessary is that the practitioner evaluates Mrs X's subjective experience and determines if there is clinically significant distress. Again this evaluation forms only one part of the diagnostic process. If the distress experienced by Mrs X is found it to be sufficiently severe, it is enough to conclude that she may have some unspecific mental disorder.

At this point it becomes a question of epistemology. Is it necessary that a practitioner *knows* that what Mrs X presents with is some undetermined mental disorder? The question is not whether she has a mental disorder, rather it is whether her knowledge of that fact is what settles the when question.

The answer to this must be no. Firstly consider Mrs X herself. She phoned the psychologist and made the appointment, perhaps because she recognised herself that she needed help. As is likely the case it might have been a colleague, friend or loved one that recognised her need for assistance. This is because knowing that there is mental disorder need not indicate the need for help. We can even imagine that none of those who suggested she seek help have any knowledge of mental disorders, only the knowledge that psychologists help this sort of distress. Moreover, as we have seen in the above section, psychiatric healthcare often treats non-disorders.

One might object at this point that while Mrs X would be someone who requires help or intervention, there will be many people who will not require intervention who would arrive at the office of a practitioner. The answer to this is that if Mrs X was able to determine that she needed assistance without knowledge of mental disorders then it is not the knowledge of mental disorders that makes possible an accurate assessment of whether or not treatment is warranted. As Bolton points out, it is the finding of significant finding, which determines our need to treat. It is the informed judgment of the practitioner which makes for accurate assessment of the significance or severity of the harm that is being experienced.[23]

To see that *knowing* that the patient suffers from *some mental disorder* is irrelevant when deciding when to treat, let us consider this thought experiment in which the second diagnostic process is eliminated.

> We could imagine a possible world in which human beings suffer in the same sorts of ways as humans in our world. Unlike that world there has never been much of a medical profession and certainly no Sigmund Freud to open up the field of psychiatry. On that world there is no manual of mental disorders and there is no concept of mental disorder. However we can easily imagine some or other profession springing up as a means to help those who experience the phenomena we describe as mental disorder on earth. On this world the professionals have as robust a causal picture of what is going on as we do here on earth, but with no manual or concept of mental disorder. It is hard to imagine that these individuals would be unable to decide on when to apply their skill or trade, simply because they have no concept of disorder. They would likely go through the same processes described above and come to the same conclusion.

This is because knowing when intervention is needed depends on a judgment about harm and not knowledge that there is a mental disorder. The concept of mental disorder is a statement

[23] We might still ask how the practitioner is to decide on what qualifies as significant distress or not. While this certainly is a difficult problem to find a solution to, it is by no means unique to the no-disorder position. It is a problem that is faced by the non-naturalist position like the one proposed by Bolton. It is well beyond the scope of this dissertation to provide an account of reliably evaluating the significance of another's subjective experience of distress. For this paper I will settle for accepting that though complex, it is by no means unique to this position.

as to the category, or family kind to which the individual bears resemblance. Moreover, a practitioner is only ever able to arrive at that conclusion by first acquiring all the information that settles the when to treat question *as well as* completing the second quantitative diagnostic process. Knowledge of the category in no way affects judgments regarding the significance of distress. This is because the knowledge of the category necessarily depends on the outcome of that judgment, but the judgment need never result in that knowledge.

To put it simply, knowing that treatment is warranted depends on the outcome of the evaluation of harm. The process of arriving at that judgment is only one of the necessary processes that results in a diagnosis. Furthermore, it is not necessarily true that that judgment will lead to a diagnosis.

That the harmful phenomenon also happens to resemble a category called mental disorder is no more than incidental. The absence of a diagnosis of mental disorder would not negatively affect a practitioner's ability to answer the when question of the need to treat problem, because the ability to do so is resolved in information acquired prior even to the ability to make a diagnosis.

However this is only one part of the need to treat issue. It remains to be seen in the following section that the ability to provide effective treatment does not depend on diagnosis of mental disorder.

4.4. The How Question

It is a useful time to pause and take stock of what has been, and has yet to be argued. The remainder of the introduction to this section will be devoted to setting up the problem posed by the how question for the no-disorder approach and understanding why it is such an important and difficult question to answer.

At this stage it has been argued that a practitioner's ability to determine when treatment is warranted does not necessarily depend on the diagnosis of a mental disorder. The aim of this section is to provide arguments that the same is true of the practitioner's ability to make decisions regarding the nature of treatment. Put another way the practitioners ability to answer the how question or the appropriateness of treatment more specifically, does not necessarily depend on a diagnosis of mental disorder.

In the previous section it was argued that knowledge of disorder depends on the outcome of the clinician's judgment as to the extent of the harm. However, the result of that very same judgment accounts for a significant portion of the reasoning to determine the appropriateness of treatment generally. In the end, a clinician's judgment depends on *that* judgment regarding extent of the harm and not a positive diagnosis of a mental disorder. As was shown above the knowledge regarding the category is not necessary to decide whether a person requires some type of help.

However this is only partially true. As was discussed above the when question is not entirely separate from the how question. The 'when' question can be settled in a vague sort of way. It is settled by the outcome of a clinician's judgment as to the extent of the harm. However, the question as to the need to treat depends, in part, on at least one other factor. As Bolton suggests, the nature of the harm can also determine the type of treatment that is offered by a practitioner. He rightly points out there are some cases in which, though there is sufficient harm, the treatment employed is watchful waiting, rather than active intervention.

> “The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment. Need for treatment is a complex clinical decision that takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient's distress (mental pain) associated with the symptom(s), disability related to the patient's symptoms, risks and benefits of available treatments, and other factors (e.g., psychiatric symptoms complicating other illness). Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care. 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. (American Pychiatric Association, 2013, p.20)”

In cases where watchful waiting may be most appropriate, Bolton (2008) suggests that such a decision may rest on the self-limiting nature of the harm. It is at this point that one might believe that diagnosis provides the answers to these sorts of questions. For example the DSM 5 speaks directly to prognostic factors, risk factors, what to expect during the course as well as information regarding the onset and development of the disorders. As such, knowing the diagnosis can provide information as to what to expect.

Take as an example Adjustment Disorder in the DSM 5. The Diagnosis comes with an expectation that the symptoms will be self-limiting within 6 months given the absence of the stressor. This enables the clinician to perhaps employ a watchful waiting approach. The same holds for cases where as a result of some stressor a person experiences severe even if appropriate levels of distress. We can know that it may be appropriate to monitor such an individual to ensure that the distress does not manifest in some way that brings with it either an increase in risk or a likelihood that the distress will no longer diminish of its own accord over time.

It is equally possible that a person presents with recurrent Major Depressive disorder. We can know that there is a greater risk of future relapse, perhaps with suicidal ideation, as well as knowing that such cases may come with co-morbid personality disorders. We equally learn something about the nature of the treatment that would likely be required in such a case. Of course this is what Bolton argues as well.

It is not simply a determination as the extent of the distress that guides the clinician as to the appropriateness of active treatment. What does assist the practitioner is knowledge as to the risk factors that are associated with the particular presentation or the nature of the symptoms[24]

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If we have no concept of disorder, one might contend that this may make the process of answering the questions as to the need to treat, at best unduly complicated and at worst impossible.

A further related criticism may be levelled at this point. If there is no concept of disorder how are we to know what the most effective treatment would be. It is not a matter of the appropriateness of treatment in general that is the concern, but rather that practitioners are guided in their selection of appropriate treatments by the diagnosis. There are many treatment guides available which pair diagnoses with the most effective treatments. This is most notably true in the case of psychiatry and pharmacology, where the combinations of possible pharmacological treatments are listed under specific diagnoses. In some ways diagnosis is a mainstay in the selection of appropriate intervention.

As such, it is important to provide some account of how mental disorder is not necessary if a practitioner is to decide on issues around need to treat as well as the nature of that treatment. I

[24] As Bolton points out.

will argue that at present what settles both matters is not knowledge of diagnosis, but rather understanding the causes of the distress.

In the previous section it was argued that a practitioner may be able to determine if treatment is generally warranted without a concept of mental disorder. However, it is not so clear that the type of treatment that is warranted does not depend on a concept of mental disorder or a diagnosis. It may still be the case that diagnosis makes it possible for practitioners to afford effective treatment. It is this proposition that this section aims to address.

It will be argued that what is necessary for a practitioner to afford effective treatment is:

a) Knowledge of the mechanisms/systems/processes that proximally cause those symptoms or complaints.
b) Strategies that can be employed to alleviate distress that arises from those proximal causes.

In this section it will be argued that *a* and *b* follow from four assumptions that form a part of any treatment paradigm. It will be argued that when it comes to treatment any theory supposes that:

1. there are mechanisms/systems/processes that are the proximal causes of psychological phenomena;
2. the manner that those mechanisms/systems/processes function sometimes results in distress;
3. the nature of the distressing psychological phenomena depends on the way in which those mechanisms/systems/processes are functioning;
4. treatment strategies aim at alleviating the distress by altering the functioning of those mechanisms/systems/processes.

More to the point, when we understand treatment in the ways described above it is easy to see that the diagnosis of a mental disorder is not necessary to decide on treatment.

In this section each of points 1 through 4 (above) will be defended with reference to Mentalizing Based Therapy (MBT). Each of these points will be discussed in turn as they are to be found in MBT. Moreover, for the sake of brevity, a short description of one other treatment will be discussed to show how other treatment modes fit into this model.

4.4.1. Mentalizing Based Therapy

One might well ask what is MBT? First and foremost it is an approach to treatment. However it is an approach to treatment which makes explicit claims as to the pathways which give rise to severe psychopathology. MBT argues that the development of a meaningful and coherent self depends on the quality of attachment in early childhood and the capacity for mentalizing (Bateman & Fonagy, 2004). It is the contention of MBT theorists that the symptoms of severe psychopathology involving representations of the self can be understood in terms of the manner in which the individual mentalizes themselves and others (Fonagy *et al.,*2012; and Fonagy, 2000).

What then is mentalizing? Fonagy *et al.* (2012) explain that:

> "Mentalizing is a form of social cognition. It is the imaginative mental activity that enables us to perceive and interpret human behaviour in terms of intentional mental states." (Fonagy *et al.,*2012, p.4)

In short, mentalizing is a process whereby the behaviours of others are interpreted as being intentional. The process involves attributing to the actor, motives which are driving them. The actor can be the self or another. The ability to interpret others as intentional agents is considered a preconscious process which develops and becomes more sophisticated.

This capacity to mentalize must be understood as a developmental process which arises in the context of a secure attachment relationship. Fonagy *et al.,(2012)* argue that:

1. Understanding the behaviours of others in terms of their likely thoughts, feelings, wishes and desires is not entirely a constitutional given but to some degree a developmental achievement.

2. The acquisition of this capacity depends on the quality of attachment relationships- particularly, but not exclusively, early attachments, as these reflect the extent to which our subjective experience was adequately mirrored by a trusted other.

3. The quality of affect mirroring effects the development of affect regulative processes and self-control (including attention mechanisms and effortful control) and the capacity for mentalisation.

4. Disruptions of early attachment and later trauma have the potential to disrupt the capacity for mentalizing and, linked to this, the development of a coherent self-structure. (Fonagy *et al.,*2012. p.4)

As a child develops, they are faced with having to make sense both of their internal and their external world. To do this effectively requires a secure attachment relationship with a caregiver (Fonagy, 2000). Evidence of this can be found in false-belief tasks described by Fonagy (2000).

His discussion begins by describing a false belief study (Fonagy, 2000). In the study children are asked what they think is inside a candy box. Usually the child would respond saying that there were candies in the box. However it was revealed to the child that in fact there were pencils in the box. When asked what their friend waiting outside would say was in the box, a response that the friend would believe there were pencils in the box constitutes a failure of the false belief test. However, some children would respond that the other child would think that there were candies in the box. These were the ones that had passed the test.

What is happening in this experiment is that those that failed did not have the ability to interpret the mental state of their friend (Fonagy, 2000). They were not able to separate their own mind from that of their friend. On the other hand, those that passed the test were able to ascribe to their friend a set of beliefs that was different to their own.

Fonagy (2000) argues that when this study was repeated it was found that the group that successfully passed the false belief test were three times more likely to have a secure attachment relationship to a caregiver. Furthermore, it was found that the ability of the caregiver to mentalize was higher if there was a secure attachment relationship.

He argues that this shows that the ability of a child to mentalize depends on the caregiver's mentalizing capacity and is mediated by the secure attachment relationship (Fonagy, 2000). This is instrumental in the development of the self as an intentional agent which is understood as being central to understanding psychopathology.

> The securely attached child perceives in the caregiver's reflective stance an image of himself as desiring and believing. He sees that the caregiver represents him as an intentional being, and this representation is internalized to form the self. "I think, therefore I am" will not do as a psychological model of the birth of the self; "She thinks of me as thinking and therefore I exist as a thinker" perhaps comes closer to the truth. If the caregiver's reflective capacity has enabled her accurately to picture the child's intentional stance, then he will have the opportunity to "find himself in the other" as a mentalizing individual. (Fonagy, 2000. P.1132)

Putting it in a simplified example form might serve to explain this process. In the presence of a secure attachment relationship, a mother is in a position to reflect on the child's internal world. When a child experiences an unaccounted for affect, the caregiver will reflect and name the emotion but display an affective state state that is not compatible (ideally a calm affect) with the one the child is experiencing. As a result, the child generates a second order

representations of that mental state as a part of their own mental and affective self (Fonagy *et al.,*2012). Fonagy *et al., (*2012) refer to this as a marked and contingent response. At the same time it emphasises that the child's mental states need not be identical with the mental states of the caregiver (Fonagy *et al.,*2012). In this the child is able to interpret social interactions with greater complexity, taking into account that their mental state and intentions may differ from those with whom they are engaging. This would represent an individual with a high degree of mentalizing ability. There is evidence to suggest that these individuals are able to cope better with stressful life events and their own negative affects[25] (Fonagy *et al.,*2012).

To understand distressing psychological phenomena we need to understand how there is a disruption in development of the capacity to mentalize and the development of a coherent self. It is argued that where a child is not in a secure attachment relationship they never develop the ability to mentalize and instead interpret themselves and others in pre-mentalistic modes (Bateman & Fonagy, 2004). That is to say, in modes of functioning which predate the development of the capacity to interpret their own behaviour as coming from within as well as interpreting others actions as being intended towards complex ends. This will be described in greater detail as this section continues.

It is argued that different pre-mentalizing modes of functioning develop from insecure attachment relationships. Moreover, as a result of those relationships the self is not able to develop into a cohesive or what Bateman and Fonagy (2004) call, a constitutional self. In the case of an insecurely attached child, the affective or mental states of the child are not marked and/or seems to cause a similar response in the caregiver (Fonagy *et al.,*2012). As such, these are never fully integrated as self-states. When confronted with these states in the future they

[25] For the research on this a detailed account can be found in Fonagy *et al.* (2012). Though this is an interesting research area, to focus on this would be outside of the scope of this project. It is enough for the purposes here to accept that this approach makes these claims to the causes of psychological phenomena, not necessarily the validity of those claims.

may be regarded as alien and dangerous resulting in affect dysregulation and failure to mentalize, favouring pre-mentalizing modes of functioning. (Fonagy *et al.,*2012) .There are different modes of functioning that could develop from different failures by the caregiver. For example one way of interpreting the world in early childhood is that the child assumes that all knowledge they have is shared. Their internal mental landscape simply is identical with the external world around them. This is referred to as psychic *equivalence mode* (Fonagy *et al.,*2012; Bateman and Fonagy, 2004). A second way of interpreting the world might be in a teleological mode (Fonagy *et al.,*2012). In this mode, intentions are only regarded as being set towards rudimentary and observable ends (Fonagy, 2000). In this way there is no room to understand the behaviours of others in terms of their own internal mental states.

These are just two of the modes that are described by the MBT theory. For the purposes of this dissertation they will not all be discussed. This is because what remains to be shown is firstly that understanding the modes of functioning and the individual's perceptions of the self, results in specific symptoms (or at least is formulated in that way by those that advocate MBT), and secondly to show that treatment centres around working with modes of functioning to enhance mentalizing capacity (to solve a wide range of distressing psychological phenomena).

Before this is possible, one needs to first understand that there are multiple factors at play in the acquisition of mentalizing capacity that are not strictly related to the attachment relationship (Fonagy *et al.,*2012). This is in line with some of the arguments that were discussed above in which it was argued that the presence of a psychological phenomenon can be determined by many possible pathways, some of which are genetic and some of which are environmental.

For a full list of these it is best to read Fonagy *et al.* (2012). What is required for present purposes is just one example of how mentalizing can be effected. This example will be used to explain later how treatment does not rely on diagnosis of a disorder but rather on understanding the processes involved in change.

One factor which greatly impacts on the ability of an individual to mentalize and indeed develop their capacity to do so as well as their constitutional self, is the matter of arousal.

It is argued that the ability to mentalize is greatly affected by an individual's level of arousal.

Depending on the type of attachment strategies that are used by the individual, one can expect different patterns of mentalizing. Arnsten's dual arousal system is favoured by Fonagy *et al.,*(2012) as a way of understanding how mentalizing strategies change over time.

The ability to mentalize has been associated with neuro cognitive systems in the lateral prefrontal cortex, medial, parietal cortex and lateral parietal cortex (amongst others) (Fonagy *et al.,* 2012). In comparison, pre-mentalizing modes have been understood as being controlled by subcortical systems (Fonagy *et al.,* 2012).

In cases where a person tends to form secure attachments, the threshold for stress at which point they revert to pre-mentalizing strategies is high, meaning that these individuals can cope with a significant amount of stress before they lose the capacity to mentalize (Fonagy *et al.,*2012). Equally, once they have lost this capacity they are quick to return to effective mentalizing (Fonagy *et al.,* 2012).

In comparison, those who have insecure attachment strategies (such as having a need for intense attachment or favouring no attachment) or disorganised attachment strategies, have a lower threshold (Fonagy *et al.,*2012).. They resort to pre-mentalizing modes of functioning

under relatively low levels of arousal. Furthermore, they take longer to regain their capacity for effective mentalizing (Fonagy *et al.,* 2012).

Paradoxically, there is evidence to suggest that too little arousal is also associated with deactivation of the prefrontal systems responsible for mentalizing (Fonagy *et al.,* 2012). What this means is that some mild arousal is conducive to effective mentalizing. This will become of importance later.

Interestingly, what has been found is that while increased stress and arousal are associated with activation of the subcortical functions and posterior cortical activation, too little arousal, has a similar effect.

How then do modes of interpreting and self-representations account for symptoms? It makes sense to begin by focussing on a few symptoms associated with Borderline Personality Disorder. Fonagy (2000) argues that we can understand several of the symptoms synonymous with this psychopathology in terms of a teleological mode of functioning as well as the individual's experience of their own mental states which were never integrated as mental or second order representations of themselves. Iinstead they are experienced as alien, confusing and threatening.

A starting point is the unstable sense of self (Fonagy, 2000). He argues that the unstable sense of self derives from the fact that these individuals have not integrated some of their own mental states as a part of their self. These states are regarded as alien and as such are externalised onto significant others with whom they are in relationship (a kind of projective identification[26]) (Fonagy, 2000). As such, these individuals sacrifice a real relationship with the other who manifests behaviours that are the internal representations of their partner

[26] This is a point made in (Fonagy *et al.,* 2012).

(Fonagy, 2000). These individuals therefore are likely to have many relationship failures (Fonagy, 2000).

Here we can see how understanding the psychological phenomenon depends on understanding the underlying processes that result in that phenomenon. The power of this way of formulating the symptoms becomes more enticing when we see how it explains other related symptoms in similar terms. Where there are unintegrated mental states which fail to be seen as a part of their constitutional self, there is also an over reliance on pre-mentalizing modes of functioning. So, the well-meaning but accidentally harmful actions of others might be interpreted in a teleological manner. For example, instead of understanding the shop keeper as accidentally mistaking your R20 note for a R10 note could explain their giving you too little change (Fonagy, 2000). But this requires a complex interpretation as to the motives of the shopkeeper. On a pre-mentalistic mode such as a teleological mode, the action would more likely be interpreted in light of the rudimentary explanations such as the intention to cheat (Fonagy, 2000). Functioning in this sort of pre-mentalistic mode explains the irritability and emotional instability that is a common symptom which marks Borderline Personality Disorder.

Of course it is argued that this approach applies to more than simply Borderline Personality Disorder. Fonagy *et al.* (2012) argue that

> "[d]ysfunctional mentalizing leading to disorders of self-experience occurs in all severe conditions that lead to referral for psychological therapy." (Fonagy et al, 2012, p.3).

It is argued that from eating disorders to schizophrenia we can understand the symptoms of these psychopathologies in terms of attachment, mentalizing and the sense of self (Fonagy *et al*., 2012). For the time being we will have to settle for just the example above.

Consider for a moment the assumptions that are built into treatment approaches. What has been shown here so far is that in MBT indeed satisfies points 1 through 3 that were outlined above, regarding the assumptions behind treatment. Let us consider each of them in turn with the capacity to regulate one's affect as an example.

1. there are mechanisms/systems/processes that are the proximal causes of psychological phenomena;

Affect regulation depends on complex system of processes. For the MBT approach these processes are the capacity to mentalize and the presence of a constitutional self. In this case one might consider the ability to mentalize along with a coherent self-structure as being proximal causes (in part) of this capacity. What is of importance is that the emergence of psychological phenomena is explained in terms of sets of proximally efficacious systems/mechanisms/processes.

2. the manner that those mechanisms/systems/processes function sometimes results in distress;

For MBT, it is argued that due to certain circumstances, the capacity for social cognition or mentalizing is hindered in some way such that functioning in non-mentalizing terms can result in distress. The example above of the shopkeeper who gives too little change comes to mind. If the person has a limited ability to mentalize and functions in more pre-mentalistic modes, such an altercation could result in several different affective responses, over which that individual will have limited control. This brings us neatly to point 3.

3. the nature of the distressing psychological phenomena depends on the way in which those mechanisms/systems/processes are functioning;

As was described above, different symptoms must be understood as being the result of different failures of mentalizing functions. The emotional instability described above could come from functioning in pre-mentalizing modes. However, we can understand the unstable sense of self in terms of the individual's unintegrated self as discussed above. In this case the need to account for unacknowledged aspects of the self is achieved through relationship to a significant other. The different symptoms speak to different mechanisms that proximally cause them.

4.4.2. Treatment and proximal causes.

One through three may be true for treatment modes but it remains to be shown that 4 is true. In this section some of the specifics of treatment of MBT will be discussed. What will become clear is that MBT utilizes specific methods that depend on the practitioner having knowledge of how different systems and processes behave such that they can reduce distress.

A good place to begin is by looking at what MBT claims to aim at with it its treatment. It is said that:

> "it is a therapy to enhance capacities of Mentalization and to make them more stable and robust so that the individual is better able to solve problems and to manage emotional states (particularly within interpersonal relationships), or at least to feel more confident in doing so. Our intention is to promote a mentalizing attitude to relationships and problems, to instil doubt where there is certainty and to enable the patient to become increasingly curious about his or her own mental states and those of others. It is assumed that as a result, the problem behaviours attributable to limitations in mentalizing will be addressed." (Fonagy *et al*., 2012. p.274)

This simple statement on its own might be enough to do the work for this section. In it we can see that the aim is to deal with exactly those proximal causes discussed above. MBT claims

that it is with limited mentalizing ability or a propensity to use pre-mentalizing modes of social cognition that distressing psychological phenomena occur. The aim is to enhance mentalizing capacity such that those phenomena are addressed, be they problem behaviours or managing emotional states.

This is consistent with point 4 of the assumptions that all treatment modes follow that was made above. Namely that:

4. treatment strategies aim at alleviating the distress by altering the functioning of those mechanisms/systems/processes.

Moreover it achieves this end by proposing specific strategies that are designed to alter the mode of social cognition to a more robust mentalizing one.

Consider one of the recommended approaches to treatment of a patient who utilises pre-mentalizing modes of functioning. To this end;

> "the attitude of the therapist is crucial. The therapist will stimulate a mentalizing process as a core aspect of interacting with others and thinking about oneself. In part, this will occur through a process of identification in which the therapist's ability to use his or her mind- and demonstrate delight in changing his or her mind when presented with alternative views and better understanding- will be internalised by a patient who gradually becomes more curious about his or her own and others minds and consequently becomes better able to reappraise him-or herself and understanding of others." (Fonagy *et al*., 2012 p.277)

What this is speaking to is not some diagnosis of a mental disorder[27]. It is describing a process

[27] One might be concerned that even for the MBT therapist some type of diagnosis takes place. Perhaps it is simple diagnosis that there is an impaired capacity to mentalize rather than a specific mental disorder. Of course diagnosis in a broad sense will always be necessary. In this way diagnosis simply refers to the process whereby the nature and causes of the distressing psychological phenomena are identified. However this is different from the diagnosis of a mental disorder which brings with it many assumptions around normality and abnormality that need not be present for the more broad type of diagnosis that is being described here. The diagnosis in this case is used to assess the manner in which mechanisms are functioning or operating such that a given psychological phenomena is the result. In the case of the diagnosis of a disorder the diagnosis is a statement of normality or abnormality. I thank Proressor Lindegger for bringing this potential concern to my attention.

through which the capacity to mentalize is enhanced. Moreover, it is understood, that it is the limitations of that capacity which form the proximal causes of distressing psychological phenomena.

To put it another way, the intervention must first identify the nature of the distress. The practitioner then employs strategies which directly utilise pathways to affect change to those process that result in distressing psychological phenomena. From the quote above it can be seen that it is contended that by adopting a mentalizing attitude, the therapist models for the patient how to go about interpreting minds of self and others.

The claim is that by doing so the patient will begin to learn how to mentalize more effectively. If we recall it is by mentalizing effectively that the individual is able to avoid many distressing psychological phenomena. This is an example of how the strategy makes use of knowledge as to how to work with the underlying processes that result in psychological phenomena.

One might at this point be concerned that this is more than goes on in the mind of a practitioner. It is not contended here that this is what practitioners do at present, but rather that this is all that would be necessary. Nonetheless the following example is an example of how the MBT practitioner does in fact require knowledge of the underlying processes when making real time intervention decisions

It might serve us well to make a brief example of one specific recommendation of MBT treatment. In cases where a patient is overly aroused and has lost any capacity for mentalizing, it is recommended that the therapist make containing comments that require little mental processing (Fonagy *et al*., 2012).

> "In MBT, therapists follow the general principle that the greater the patients emotional arousal, the less complex the intervention should be." (Fonagy *et al*., 2012 p.281).

This will allow the patient to regain or resume mentalizing (Fonagy *et al*., 2012). Rather than working on topics that would stimulate arousal, the therapist should contain the individual with safe and supportive comments that would de-escalate levels of arousal (Fonagy *et al*., 2012).

This is informed by knowledge of how the capacity to mentalize is affected by emotional arousal. As such it is the responsibility of the therapist to monitor levels of arousal and act such that the intervention is always at a level that the patient can practice mentalizing. For the purposes of this dissertation it should be clear that treatment is not guided by the disorder. In fact the specifics of the treatment are guided by an understanding of how best to affect change to the systems that result in non-distressing psychological phenomena. In this case the system is a capacity to mentalize

That treatment aims at affecting change to causal pathways that result in distressing psychological phenomena is even more evident when we see that the guide is even more nuanced. For example, in some cases if a patient becomes over aroused, the therapist will feel that they ought to comfort their distressed patient (Fonagy *et al*., 2012). That the therapist feels an urge to comfort the patient is evidence that the patient has activated attachment systems that impair mentalizing capacity (Fonagy *et al*., 2012). In this case the therapist is encouraged to,

> "…curb his or her natural tendencies to become increasingly sympathetic when the patient becomes emotional and to distance him or herself emotionally by becoming less expressive, even if only momentarily." (Fonagy *et al*., 2012. p.69).

This is to ensure that the person does not activate attachment strategies that would ensure that they lose mentalizing capacity (Fonagy *et al*., 2012). This is an example of how MBT provides explicit instructions as to how to go about enhancing mentalizing capacity. The

strategies are derived from an understanding as to how the processes that cause distressing phenomena function and behave over time and in different circumstances. Moreover, the practitioner is required to make direct use of their knowledge of the modes of functioning at any given time.

For the MBT practitioner, what is required is an assessment as to the mode in which the patient functions (Fonagy *et al*., 2012). For this reason a range of assessment tools (from formal assessment to mentalizing the transference and counter transference) are suggested so that the practitioner can get an idea about the way the patient interprets themselves and others (Fonagy *et al*., 2012). With this information there are many specific techniques suggested for any of the mentalizing styles (Fonagy *et al*., 2012).

Treatment depends on presumptions as to the causes of psychological phenomena and directly intends to reduce those symptoms by affecting changes at the level of those mechanisms.

4.4.3 Summary of the How Question

One concern might well be that this only applies to MBT and not to other treatment approaches. Of course one good reason for selecting MBT is that though its treatment guide lists treatments for specific disorders, the mechanisms that give rise to their distressing symptoms are the main focus of both aetiology and treatment.

Nonetheless it would seem that other treatment modes for specific distressing psychological phenomena could be argued to follow the same pattern described above. For example people who are currently diagnosed with recurrent Major depression can be treated following the guides of Mindfulness Based Cognitive Therapy (MBCT). If this phenomenon were described in non-disorder terms we might still see that can be used to treat it. Moreover it could be shown with more time that MBCT follows the same four rules outlined above.

For the sake of brevity, take for example point 3, which suggests that it is assumed that the nature of the distressing psychological phenomena depends on the way in which those mechanisms/systems/processes are functioning.

With some time, an argument could be made that that MBCT too makes this assumption. For example, one might be curious as to why the phenomena of bouts of depressed mood are experienced by a particular patient. The MBCT approach offers some explanation of the mechanisms that result in just this sort of phenomenon. Segal *et al.* (2013) argue for example that when it came to depression, "Negative thinking could *cause* depression. In addition even if such thinking had not been the first cause of an episode it could *maintain* the episode once it had started." (Segal *et al.,* 2013 p.21). Moreover when it comes to the recurrence of depression they argue that in some individuals "just a small increase in sadness for those who had been depressed before could lead to a reinstatement of the thinking patterns they had experienced when depressed" (Segal *et al*., 2013 p.29). In contrast, patients who had never been depressed would show relatively less negative thinking when they experienced a small amount of sadness (Segal *et al*., 2013). Furthermore, the greater the degree of shift in negative thinking following a sad mood, the more likely the person will enter a depressive episode (Segal *et al*., 2013).

When it comes to assumption 4 we can see that MBCT assumes that its intervention brings about a change such that the negative thoughts do not cause a further deepening of the sad mood. A brief summary of the approach is that it is

> "… a theoretical model that emphasized the importance of changing patients relationships to their negative thoughts and feelings. We had moved away from thinking that the key ingredient in cognitive therapy (the reason why it had such long lasting effects) was that it changed the degree of a person's belief in his or her thoughts and attitudes. Instead we believed that the key was whether people could learn to take a decentred perspective on their patterns of thinking." (Segal *et al*., 2013 p.43)

If argued in the same detail as MBT above it could be shown that the mechanism of change for Segal *et al*., (2013) focuses on affecting change to the processes that cause the distressing psychological phenomena. In this case the aim is to use mindfulness meditation techniques to change a person's relationship to their automatic negative thoughts, thereby reducing the risk of relapse (Segal *et al*., 2013).

If argued in a similar way to MBT above, MBCT would likely be explained in much the same way as MBT. However for now it will have to suffice to show that the theory appears to formulate distressing psychological phenomena in terms of some underlying proximal cause. Moreover treatment aims at alleviating distress by manipulating those mechanisms with specific strategies whose effect on the mechanism is understood[28]. Similar arguments could be made to show that psychiatry equally utilizes a similar treatment approach.

As for the arguments in this dissertation, it should be clear that different modes of treatment formulate distressing psychological phenomena in terms of some set of proximally efficacious mechanisms. Moreover the intervention itself is built around knowing how to intervene such that those mechanisms function in such a way that there is no longer distress.

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[28] An example of this might be found in the contraindication of MBCT for those who currently exhibit suicidal ideation (Segal *et al*., 2013). The explanation of this is that in meditation the mind seems to fixate on suicidal thoughts which escalates the problem (Segal *et al*., 2013)

What this means then, is that what is required is not a diagnosis of a mental disorder. Deciding on how to treat depends on a practitioner's a) knowledge as to the mechanisms that proximally cause a given distressing psychological phenomenon and b) knowledge of how those systems can be affected such that the result is an alleviation of distress.

This is all knowledge that can be applied as soon as the practitioner has ascertained the nature of the distressing psychological phenomena (i.e. the symptoms and complaints). As with the previous section, this information is available to the practitioner irrespective of whether or not they actually make a diagnosis. For that reason, a diagnosis is not necessary for treatment.

While it might be true that treatment is often decided on following a diagnosis, it is by no means a necessary condition. What is required is that the practitioner gathers information regarding the symptoms and complaints. This is consistent with the COA which focuses primarily on the symptoms. Moreover it lends credence to the idea that the focus of research should be on understanding the causal pathways to specific symptoms. This is because knowing how those pathways behave is what makes treatment effective.

5. Concluding remarks

Before concluding ,some limitations and potential objections to the arguments set forth here will be addressed. In the beginning of this section four potential criticisms or limitations will be discussed .

5.1. Limitations and criticisms

Firstly one might be concerned that not enough time was spent defending the emphasis placed on proximally causal mechanisms. Moreover, one might be concerned that it is not altogether clear what mechanisms count as proximal causes. There are two responses to this. The first is that, as was briefly stated, Rutter (1997) argues that the types of mechanisms that affect psychological states can be environmental, genetic or biological. He does not limit himself to any one of them. It is the contention that proximally efficacious mechanisms can take on many forms. The limitation of this dissertation is that it is not possible to provide a detailed exposition of the nature of proximal causes. The second response is that the aim here is not to say that we know exactly what the proximal causes are at present. What is necessary for the purposes of this paper is to show that, conceptually, diagnosis is not necessary for treatment simply because treatment modes *at present* treat what the best evidence proposes to be proximally causal mechanisms. While it is acknowledged that substantially more can be said of these proximal causes it is not necessary for this dissertation. It is enough to show that conceptually proximal causes play an important role in treatment, *whatever they are.*

Secondly one might be concerned that the discussion of Bolton and Wakefield's debate is too brief and not enough evidence is given to accept that mental disorder is in trouble simply because evolutionary dysfunction is in doubt. Moreover it might be a concern that the discussion does not defend thoroughly enough why Bolton's view is accepted over Wakefield's.

Absolutely this is true. Wakefield's account is a very well detailed argument and on many occasions argues against critics who suggest evolutionary dysfunction is a value conception in disguise. However, in this dissertation Bolton's criticisms are assumed to hold. Particularly because even though the first objection might not hold, the second certainly does. Even if evolutionary dysfunction is not a value concept, it is still entirely too speculative. That said, the discussion of Wakefield's solution to over-pathologising was an attempt to briefly draw

attention to how reliability and validity of diagnosis and research suffer in the absence of an objective criterion. For the purposes of this dissertation this will have to suffice. The aim is to simply show that the goal in this project is not trivial because there is at least some doubt as to how useful and reliable the concept of mental disorder really is. If it is at question then there is merit in looking at how treatment would be possible in its absence. Moreover, perhaps it needs to be seen that the arguments here are simply picking one definition (Bolton's) for the sake of argument. However, the argument in section four would not be affected too greatly even if Wakefield's definition were used. Perhaps this could be the task for a future paper.

Thirdly, it might be unsatisfactory to the reader to simply point out only one alternative to mental disorder without much of a defence. Again this is simply a limitation of the scope of this project. For these purposes it is sufficient to simply show that there are already alternative approaches that do not make use of the concept of mental disorder. The argument was aimed at showing that the treatment issue is not a trivial one. There are already some who chose to abandon the concept (as discussed above) and as such it is necessary at the very least to raise an example of just such an account. Detailing alternate approaches as well as the complaint-oriented approach is again a useful project but not one that could be dealt with here.

Finally one criticism that might be raised is that in discussing the 'when' question, no mention is made of psychopharmacological treatments and that only one example of psychological treatment modes is insufficient to prove that treatment is not necessarily an issue of diagnosis. This is potentially a far more challenging criticism. As with the previous criticisms this is a direct result of the limited scope. In order to do justice to the 'when' question the discussion required that many of the theoretical assumptions needed to be discussed. That said, towards the end of the section a very brief discussion of MBCT offered

to show how other treatment modes might be argued to follow the same pattern as was argued for in MBT. When it comes to psychopharmacological treatments I believe a similar point could be made. When it comes to medication it could be argued that treatment depends on understanding how a particular medication affects change to physiological structures that are understood to be either proximal causes of distressing psychological phenomena or proximal causes of alternate alleviating psychological phenomena. Again, while this would require a great deal of argument, this sort of question is not one for such a small project.

Ultimately there are many questions that deserve more attention in future works. However, this is not the place for them. The aim of this dissertation is only to argue that conceptually, treatment issues are not necessarily resolved by diagnosis of a mental disorder, not that diagnosis of mental disorder is unnecessary altogether.

5.2. Conclusion

The aim of this dissertation is to argue that treatment without a concept of mental disorder is possible. It was argued that at present one of the best ways to define mental disorder is as a harm only concept as advocated by Bolton (2008). However some good reasons for moving away from mental disorder, particularly as outlined by Bentall (2005). His COA approach is said to address some of the many other practical issues that are said to be best handled by carefully defining mental disorder. Whether or not one accepts his approach is not the target of this dissertation. However through the discussion of Mentalizing Based Therapy it was

pointed out that formulating around treatment seems to in some ways parallel to the COA approach.

Most importantly, however, it was argued that treatment is not necessarily dependant on the making of a diagnosis of mental disorder and therefore a concept of mental disorder. It was argued that firstly, commonly what psychiatric healthcare professionals treat are not disorders. That is to say that the domain of psychiatry is not defined by mental disorder. Secondly it was argued that even in the event that one held that in cases where there would be a finding of a mental disorder (a) knowing when to treat and (b) knowing how to treat did not depend on a concept of mental disorder. Knowing how to treat depends on acquiring information as to the severity of harm experienced which in itself is necessary but insufficient to make a specific diagnosis of mental disorder. If knowledge as to the severity of harm is sufficient to know when to treat, but that knowledge is insufficient to make a diagnosis, then it must be the case that knowing when to treat is possible without a diagnosis.

On the other hand knowing how to treat is equally independent of a diagnosis of mental disorder. As is exemplified by MBT, treatment manuals require that the practitioner understands how the strategies that are recommended, affect change to the proximal causes of the particular symptoms or distressing psychological phenomena. What is of interest for the how to treat issue is not knowledge of the mental disorder but rather, all that is required is an understanding of how those symptoms arise and how to go about alleviating them which in itself is information that is necessarily available before a diagnosis of mental disorder is made. For this, treatment manuals refer to the functioning mechanisms that proximally cause distress. All of this is conceivably possible without a concept of mental disorder.

Given that mental disorder is commonly accepted as being important for treatment issues, to the positive claim that the mental disorder concept ought to be abandoned, requires an

argument to show that treatment is not affected by the absence of a concept of mental disorder. This is what has been argued here; firstly, mental health practitioners do not exclusively treat disorders, and secondly, even when disordered a patient's treatment depends on something other than a diagnosis.

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