International Journal of Law and Psychiatry 52 (2017) 7–18

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Defining “mental disorder” in legal contexts

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ARTICLE INFO

Article history:
Received 13 December 2016
Received in revised form 29 March 2017
Accepted 19 April 2017
Available online 9 May 2017

> There is no definition of a mental disorder. It's bullshit. I mean, you just can't define it (Allen Frances, lead editor of the DSM-IV, quoted in Greenberg, 2011, p. 126).

1. Introduction

If asked, most people would probably have little difficulty providing an example of a mental disorder. But if they were asked to *define* the term “mental disorder” it seems likely that they would struggle. While their response may refer to the mind “not working properly” in some way, or to some sort of internal condition that causes a person's thinking or behavior to become disordered or dysfunctional, they would probably have trouble spelling out exactly what they meant by these explanations. What does it mean for the mind to “not work properly”? When is a condition considered to be “internal”? What does it mean for a person's behavior or thinking to be “disordered” or “dysfunctional”? These questions cannot easily be answered, without the responses becoming circular.

It is important to note that these are not merely academic questions. The way in which mental disorder is defined can “configure and reconfigure the lives of real men and women” (Rosenberg, 2002, p. 250). This can be seen by considering a concrete example, such as whether “internet gaming disorder” should be regarded as a mental disorder.[1] The answer to this question will affect:

- Individuals who suffer from the alleged disorder: it may affect their access to treatment, payment for that treatment, whether they are considered to be “sick” and entitled to paid leave from their work, and the shame or stigma attached to their actions;
- Healthcare professionals: it may affect their role in treating affected individuals, what kinds of treatment are considered to be appropriate, and the funding they will receive for any treatment given;
- Insurance companies: it may affect their obligation to reimburse affected individuals for any medical expenses incurred; and
- Governments, public agencies and universities: it may affect their strategies for funding, research, intervention and treatment.[2]

In legal contexts, the classification of an individual's mental health condition as a mental disorder can have far-reaching consequences. For example, in the criminal context it can result in the individual being diverted away from the criminal justice system, being found not guilty on the basis of insanity, or having a shorter or longer sentence imposed upon them (see, e.g., Walvisch, 2010). In the civil context, it can lead to individuals being subjected to preventive detention or prevented from making decisions about their lives (see, e.g., Slobogin, 2006).

Unfortunately, the term “mental disorder” has proven remarkably resistant to being coherently defined. While this may not be of critical importance to the treatment needs of an individual,[3] it is of grave concern in those legal contexts which crucially depend on the way in which an individual's mental health condition is classified. It is essential that people working in such contexts have a clear understanding of which mental health conditions should be considered to be mental disorders, and the reasons for classifying those conditions in such a way. Without such an understanding, individuals will be treated in an inconsistent and unprincipled fashion, which is unacceptable in a legal system which purports to operate under the rule of law.

This article examines and critiques current approaches to defining “mental disorder”. It starts by presenting a brief history of psychiatric nosology, the branch of medical science that deals with the classification of mental health problems. This history provides essential context for the analysis in Part 3 of the definitions of “mental disorder” that are contained in the two main psychiatric manuals currently in use: the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, currently in its fifth edition (DSM-5); and the World Health Organization's *International Classification of Mental and Behavioral Disorders*, currently in its 10th edition (ICD-10). Part 4 highlights a number of difficulties with the psychiatric manuals' approach to

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[1] Consideration was given to including internet gaming disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). However, it was ultimately included in the section titled “Conditions for Further Study” (American Psychiatric Association, 2013, pp. 795–798).

[2] See Hyman (2012, p. 158) for a discussion of similar factors in the context of pathological gambling.

[3] While the treatment needs of a patient may not depend on whether his or her condition is classified as a mental disorder, it is likely that the funding of his or her treatment will depend on that characterization.

http://dx.doi.org/10.1016/j.ijlp.2017.04.003
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defining "mental disorder", which makes it inapt for use in legal contexts. Part 5 examines three different definitional approaches, to see if they provide a better way forward: Boorse's biostatistical theory; Wakefield's harmful dysfunction theory; and Jaspers' lack of meaningful connections approach. Substantial problems with each of these approaches are identified, which also makes them inappropriate for use in legal contexts. Part 6 draws some conclusions about the way in which law-makers should approach the definitional issue.

2. A brief history of psychiatric nosology

To explain the difficulties that arise when trying to define the phrase "mental disorder", it is necessary to delve briefly into the history of psychiatric nosology. In particular, there are two issues which must be explored: the development of the "disease entity" model of mental illness, and the rise of the phenomenological approach to psychiatric diagnosis.

2.1. The development of the "disease entity" model of mental illness

Reports of "madness" date back thousands of years.[4] For much of human history the behavior of those affected was believed to be the consequence of spirit possession, sin or other magical forces (Millon, 2004): it was not until the late 19th Century that Kraepelin and Kahlbaum developed the first modern nosological systems based on the concept of "disease entities". This was a concept which had gained widespread acceptance in relation to physical illnesses over the course of the 19th Century (Rosenberg, 2002). It became particularly influential after the development of germ theories in the 1860s and 1870s, which posited that many health problems were caused by underlying microorganisms (Zachar & Kendler, 2007, p. 560).

The applicability of the disease entity model to the field of psychiatry was seen to be confirmed at the beginning of the 20th century, when it was found that syphilitic infection caused the general paralysis suffered by many "mad" people (Bolton, 2008, p. 63). This discovery was seen to confirm two important points: that madness is the result of pathological processes in specific parts of the brain (it is a mental "illness"); and that mental illnesses, like other diseases, are discrete entities that are discontinuous with normal functioning and can be differentiated from each other (Zachar & Kendler, 2007, p. 560).

2.2. The rise of the phenomenological approach to psychiatric diagnosis

The first modern psychiatric nosologies were largely based on the clinical and personal experiences of the authors, current diagnostic usage and historical perspective (Kendler, 1990, p. 969). As a result, early manifestations of psychiatric manuals such as the DSM and the ICD were widely seen to be lacking in reliability (Mirowsky & Ross, 1989, p. 13). This changed with the publication of the DSM-III in 1980 (American Psychiatric Association, 1980). The Committee that developed the DSM-III consciously sought to be guided by the growing body of research evidence and the aim of reliable diagnosis (Kendler, 1990, p. 969). In particular, the creators of the DSM-III sought to develop diagnostic criteria that would facilitate interrater reliability.

The difficulty for the developers of the DSM-III was that, unlike in the physical sciences, few biophysical markers had been found for the disorders listed in the DSM-II. While the disease entities underlying many *physical* illnesses could be reliably identified using tests such as blood or urine analysis, there was no test that could reliably identify the disease entities underlying *mental* illnesses such as schizophrenia or depression. There was thus a need to find a different way to reliably ascertain the existence of a mental disorder in a clinical setting. This was achieved by adopting the empiricist methodology of Carl Hempel, and relying on an operationalized version of phenomenology as the basis for diagnosis (Hyman, 2012, p. 159–161; Millon, 1991, pp. 250–251).

The approach taken in the DSM-III (and subsequent versions of the DSM) is to describe the signs, symptoms and course of illness in terms that are as observational as possible, and then to classify those matters into syndromes in a well-defined way. A polythetic system is generally used, which sets out various possible criteria for a specific diagnosis, but specifies that an individual only needs to meet a certain number of those criteria to be classified with the disorder. The ICD also takes a phenomenological approach, although it does not spell out the requirements for the specified mental disorders in as mathematical a fashion as the DSM. Instead of depending on operational criteria using a polythetic system, it tends to provide diagnostic descriptions of the included conditions.

The adoption of a phenomenological approach had two important consequences. First, it resulted in the excision from the manuals of many psychoanalytic terms such as "neurosis", which were seen to be vague and unreliable (Nesse & Stein, 2012, p. 1; Van Praag, 2000, pp. 151–152). Secondly, speculation about the possible causes of the listed disorders was generally excluded from the diagnoses,[5] with the manuals taking a "descriptivist" approach (Bolton, 2008, p. 3; Zachar & Kendler, 2007, p. 557). Under this approach an accurate description of a condition's signs, symptoms, course and typical outcome is considered to be sufficient to legitimate it as a disorder.

3. Defining mental disorder: the psychiatric manuals' approach

While significant effort was expended in the late 19th and early 20th centuries developing psychiatric nosologies, little attention was paid to defining the concept of "mental disorder". This issue became important in the 1970s due to widespread protests against the inclusion of homosexuality as a mental disorder in the DSM. While these protests ultimately led to the removal of homosexuality from the manual (Bayer, 1987; Spitzer, 1981), those involved in the process felt a need to justify their decision, and to explain why certain conditions (such as depression) were appropriately included in the manual, and others (such as homosexuality) were not (Greenberg, 2013, pp. 139–141). Consequently, the American Psychiatric Association decided to include a definition of "mental disorder" in the DSM-III.

The DSM definition of "mental disorder" has been refined over time, and in its most recent incarnation states that:

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

While the ICD has never sought to define the concept of "disorder" in as much detail as the DSM, the ICD-10 contains a similar definition in a section titled "Problems of Terminology":

[4] The term "madness" is used here to emphasize the fact that the period under discussion predates the development of the disease entity model, and its related concepts of mental "illness" and "disorder".

[5] There are some diagnoses which continue to refer to at least one of the causes of the disorder. For example, the diagnostic criteria for post-traumatic stress disorder refer to the traumatic event that triggers the disorder.

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