

Chapter 2

Definition and study of mental disorders

Introduction

- 2.1 Although there is no universally accepted characterisation of mental disorder, widely used definitions are those of current international systems of classification. Thus, to quote, mental disorder *"is not an exact term, but it is used to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here."*¹ Most psychiatrists diagnose mental disorders only when an individual is unable to achieve realistic personal goals due to psychiatric symptoms. But several respondents to the Working Party's consultation pointed out that, while not wishing to underestimate the suffering that such conditions can and do cause, people who are perceived as having mental disorders may also contribute great gifts of the spirit.² One respondent, describing himself as schizophrenic, argued that *"Mental illness is also emotional distress and experience of darkness and distress that we will all experience. Is that necessarily so bad? All our lives we strive to improve and make easier our lives – where would we be without that struggle?"*
- 2.2 The report does not address criminal behaviour since this is defined in relation to systems of law and jurisdictions, and not in terms of personal dysfunction. It does, however, discuss personality disorders and these sometimes give rise to profoundly anti-social behaviour which in some circumstances may constitute criminal action. The Working Party recognised, of course, that to the extent that criminal law is concerned with responsibility, mental disorders are relevant, for example, to a plea of diminished responsibility or of insanity. The issues raised, however, go much wider than a consideration of the relationship between genetics and mental disorder. The principal concern is the decision whether to attribute culpability. While medical and scientific evidence is relevant, it is not determinative, in principle or in practice. Ultimately, it remains a decision for the Court and so goes beyond our concerns here.
- 2.3 An important category within international systems of classification of mental disorder is that of mental retardation and the Working Party has used as examples conditions which are relatively well understood, such as phenylketonuria and fragile X.³ Issues such as the ethics of genetic research into mental retardation or intelligence within the normal range, or its applications or implications however, fell outside the Working Party's terms of reference. Recently, concerns have been expressed about the ethics of genetic research into conditions involving mild mental retardation and its implications for the understanding of intelligence in the normal range. The Working Party considers that there are issues in this area, such as the criteria of intelligence, the dangers of illusory perfectionism, and the possibility of increased pressures for selective abortion, which would merit future consideration.

Definition and diagnosis of mental disorders

- 2.4 A criticism of definitions of mental disorder is that they reflect judgements linked to social circumstances. It is still the case that many features of mental disorder are defined in terms of

1 World Health Organisation (1992) *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*, World Health Organisation, Geneva, p5. Although many mental disorders constitute a spectrum, ranging from severe through mild to 'normal', the prime focus of the scope of this study is mental disorder as defined by these criteria.

2 Response by the Ethics and Genetic Engineering Network established by the Luton and Leighton Monthly Meeting of the Religious Society of Friends (Quakers).

3 In the UK, mental retardation is now more usually known as learning disability. The Working Party has adopted the term mental retardation on the basis that it is currently used in international systems of classification. It accepts, however, that this is neither a universally accepted, nor an ideal, term.

difference or deficiency as compared with a standard defined within a social context. Assumptions about what is standard, and hence about what differs from standard, will vary over time and according to cultural context.

- 2.5 Another criticism is that diagnosis of mental disorders is hampered by imprecise definitions and lack of consistency.⁴ Although there have been problems of this sort in the past, current clinical definitions of mental disorders such as schizophrenia or manic depression are now no less precise than those for some non-psychiatric medical disorders. If modern diagnostic criteria are used, there should be agreement about diagnosis between any two trained assessors. This said, individual cases can vary greatly in the symptoms displayed and their relative severity, sometimes resulting in inconclusive or conflicting diagnoses. Also, as in other areas of medicine, criteria and diagnostic categories are themselves liable to be modified as knowledge grows.
- 2.6 The real problem is that, in most cases, little is known about the underlying causes of mental disorders. Thus psychiatric diagnoses represent operational definitions, or working hypotheses, rather than well-understood entities. Unlike other diseases, there are few biochemical, radiological or physiological tests to assist in a clinical diagnosis based on history and current presentation. Nevertheless, a measure of validity may be inferred from the fact that, in many cases, it is possible to give an indication of probable outcome (prognosis) on the basis of a diagnosis and to predict to a certain extent the likely response to treatment and other clinical interventions.

Can mental disorders be explained in physical terms?

- 2.7 As in every other branch of the subject, the philosophy of mind and the philosophy of psychology are characterised by significant disagreements. Philosophical consensus is rare and generally not long-lasting. Even so current philosophical thinking about the nature of psychological phenomena is broadly anti-reductionist.⁵ That is to say, while most philosophers believe in the physical basis of the mind, they do not suppose that psychological features are reducible to physical ones in the sense that they might be wholly describable or explicable in terms belonging to physical theory. The relationship between the mind and its physical basis remains unresolved, and no easy resolution is in prospect, but, given the correlation between the two, it makes sense to consider the influence of physical factors, including genetics, on mental states. The identification and explanation of mental states, however, is taken to proceed by reference to *psychological* criteria. Any attempt to explain the psychological in terms of the purely physical will fail if, according to the predictions of the favoured physical theory, a person 'should' be in a state of depression, but he or she is patently untroubled as judged by *psychological* criteria. The psychological evidence is decisive in medical diagnoses as in ordinary life: someone is anxious if, and only if, they feel anxious and/or their behaviour expresses anxiety. This truth holds good whatever underlying physical basis there may be for the psychological condition. We have much to learn from the physical sciences about the structure and activity of the brain, but physics does not purport to be an account of persons as psychological subjects.

4 Professor Bill Fulford, University of Warwick, in his response to the Working Party's consultation argued that difficulties of definition can lead to practical difficulties and dangers. "*Much abusive practice has arisen from, on the one hand, people who are not mentally ill being treated as such (eg the institutionalised abuses of psychiatry in the former USSR), and, on the other, people being denied treatment for mental illness on the grounds that they are 'merely socially' deviant (this has become an increasing problem with shrinking resources).*"

5 For contrasting surveys and assessments of the current state of the subject, see Churchland P (1986) *The Ontological Problem (the Mind-Body Problem)* Chapter 2 in **Matter and Consciousness**, MIT Press, Cambridge, Mass & London; and Searle J (1992) *What's Wrong with the Philosophy of Mind?* Chapter 1 in **The Rediscovery of the Mind**, MIT Press, Cambridge, Mass & London; and, for a brief overview designed for non-philosophers, see Haldane J (1998) *The Philosophy of Mind* in **Encarta Encyclopedia**, Websters, London.

- 2.8 There is also a growing consensus within philosophy and the social sciences that human beings only develop fully within a social context which allows interaction with others. For example, it is widely accepted that language is intimately connected with thought. While human beings may have a natural potential for language, this can only be fulfilled in an environment in which others' use of language can be experienced. It is also generally supposed that the notion 'I' can only be applied by a being that has a concept of others ('you', 'him', 'her') and the capacity to view him or herself as an object of attention and interest to others. In short, my ability to think of myself as a psychological subject is linked to my ability to think of others as such, and to think of them as regarding me as an other.
- 2.9 There are generally held assumptions about what someone ought to think or feel in various circumstances. These constitutive norms relating belief, intention and action vary relatively little across cultures and time. Less logically rigid, but no less important, are society-specific expectations about what constitutes normal psychology. These are much more prone to vary across cultures and with time. For example, certain forms of statistically uncommon sexual behaviour regarded at one stage in social history as disordered or pathologically deviant may come to be viewed as legitimate expressions of sexuality. In clinical practice, the impact of society-specific expectations can be minimised by bearing in mind the definition of disorder adopted in this report (paragraph 2.1). According to this definition, statistically unusual sexual preferences would be classed as mentally disordered only if they were associated with personal distress or personal dysfunction.
- 2.10 One need not endorse all of the claims made under such headings as 'the social construction of normality' to see that what counts as reasonable or unreasonable, regular or deviant, healthy or morbid may differ across societies and with time. The period since the Second World War has, it seems, been one of many changes in assumptions about normality. It is as well to remember this when thinking about mental disorders. Certainly, one needs to be mindful that conditions now regarded as involuntary pathologies may come in time to be viewed as legitimate lifestyles.
- 2.11 We end this chapter by emphasising related points made in Chapter 1 about the human perspective of this report (paragraph 1.4) and in this chapter, about the relation between the mental and the physical (paragraphs 2.7–2.10). In reflecting upon standard styles of description, explanation and evaluation of human psychology it is important to recognise that the proper and primary subject of study is the person. It is also necessary to be aware that contrasting notions of order and disorder and of normality and deviancy are at least partly rooted in social norms and expectations which may vary over time and across cultures. In the domain of human psychology there are few if any timeless truths and the significance of those that are recognised is often evaluated differently at different times.