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COMMENTARY

What's wrong with 'mental' disorders?

A commentary on 'What is a mental/psychiatric disorder? From DSM-IV to DSM-V' by Stein *et al*. (2010)

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Introduction

The editorial by Stein *et al*. (2010) is timely and relevant given the development of DSM-V and the likely impact that such a development will have on mental health services in the USA. The revision of the DSM will also affect international psychiatric research and global practice thanks to the interplay between the development of DSM and ICD (Fulford & Sartorius, 2009). The editorial by Stein and colleagues is very rich and there are many themes suitable for further examination and discussion. For this response, however, we have chosen to focus on two themes: the use of the term 'mental' and the idea of psychiatric disorders being 'in' an individual.

Mental or psychiatric disorders?

Although Stein and colleagues are right that, in the Cartesian philosophical tradition, the term 'mental' has been contrasted to 'physical' in accounts where the mental is characterized by immaterial thought (*res cogitans*) and the physical by extension (*res extensa*), the term 'mental' by itself does not commit people who use it to either substance or property dualism. In other words, it does not commit people to the view that the mind and the brain are necessarily two different kinds of substances or to the view that mental and physical properties are necessarily two different kinds of properties. In fact, one might be a physicalist, a philosopher who believes that everything in nature is physical, and still use a mental vocabulary competently and meaningfully. The retention of a mental vocabulary does not undermine one's commitment to physicalism.

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In particular, the use of 'mental' is useful in contemporary psychiatric research as it denotes events or states characterized by intentionality, such as beliefs and desires, and capacities that are amenable to be assessed on the basis of normative standards, such as the standards of rationality and justification. One of the claims that we might want to explore with respect to the classification and diagnosis of mental disorders is, for instance, the extent to which behaviour is pathological when people's beliefs violate norms of rationality or people lack self-knowledge. Together with other colleagues, we have explored the importance of normative notions in psychiatry, particularly in relation to delusions and psychosis, and hence we would support the retention of a mental vocabulary when thinking about certain aspects of psychiatric disorders (Bortolotti & Broome, 2008, 2009; Broome & Bortolotti, 2009*a*; Broome *et al*., in press).

Although well-motivated, the authors' decision to turn to phrases such as 'mental/psychiatric' and 'brain/mind' seemed, on the whole, unnecessary and a little unwieldy. Recognizing the distinctiveness and usefulness of the mental vocabulary does not commit anyone to the existence of Cartesian spooky, immaterial stuff. That said, there is nothing objectionable in the use of the phrase 'psychiatric disorder', unless it is regarded as circular or trivial in some contexts. To refer to a disorder as a psychiatric disorder may not commit anyone to a theory about the nature of the disorder but may not always be informative, as in some context it is likely to be understood as applicable to a disorder when this is 'diagnosed as such by a psychiatrist', or when it 'falls under the remit of the practice of psychiatry'.

Perhaps Stein and colleagues would be sympathetic to using the term 'psychological' instead of 'mental' in some of the relevant occurrences? That is, not necessarily when identifying a disorder but when describing some of the features of that disorder. The term

'psychological' has no dualist connotation whatsoever and reminds us that, in everyday life and also in research and clinical practice in psychiatry, we do not always identify and describe behaviours (including actions, speech, beliefs, intentions, emotions) in physical terms, although we are fully aware that such behaviours have physical bases and causes (Broome & Bortolotti, 2009*b*). The use of the term 'psychological' also avoids some potential challenges of circularity or triviality that the use of the term 'psychiatric' would generate in some contexts.

Is the disorder in the individual or in the space between individuals?

The discussion of the phrase 'in an individual' by Stein *et al*. is extremely interesting but brief, given the complexity surrounding this issue. Although it may seem self-evident that disorders reside in a given individual, when examined closely the claim is controversial and carries conceptual baggage. What does it mean to claim that 'a psychiatric illness lies in the individual'? There can be at least two interpretations of such a statement. The first interpretation invites an exploration of the metaphysics of psychiatric illness. It suggests that we can compare, for illustrative purposes, some psychiatric disorders to lesions that seem to occur within an individual and to affect the individual's well-being independent of the existence of other individuals, or independent of the external environment. Such an exercise might have important implications for our future understanding of psychiatric illness.

The second interpretation would lead us to believe that Stein and colleagues intend to discuss the locus of psychiatric disorders. It is not at all obvious that the aetiology or the pathological nature of a psychiatric disorder can be all contained in the individual and explained by reference to properties of the individual. It is not clear that any condition that is regarded as a psychiatric disorder is such that it has no external (environmental or social) causes. Furthermore, it is not clear that something can be regarded as a psychiatric disorder if it is dysfunctional or disabling for an individual independent of the individual's environment or social context. To insist on an internalist position, regarding either the causes of psychiatric disorders or the reasons for their being pathological as internal to the subject, would bring back a form of 'mentalism', to which the authors would certainly be opposed.

A further point is this: could a solipsist be mentally ill? Could a person's psychiatric illness ever be spotted in the absence of a third person observing his/her behaviour within a shared environment, ascribing to his/her mental states, and making judgements about the appropriateness or rationality of those states and of his/her behaviour in general? On these three points, the anatomy and locus of a disorder, the causal history and impact of a disorder, and the detection of a disorder, we suggest that at the very least the claim that a disorder occurs 'in an individual' warrants further examination. Without further examination, it potentially allows a form of internalism to flourish in psychiatry and leads to neglect of the role of the world, society and other individuals in the understanding of a person's mental illness.

Conclusions

We have only had space to comment upon two issues raised by Stein and his co-authors. From the perspective of psychosis research at least, society and the lived environment, in addition to work relating psychological concepts to neuroscience, are important theoretical drivers (Kapur, 2003; Selten & Cantor-Graae, 2005; Kirkbride *et al*. 2006; Morgan *et al*. 2008; van Os, 2009). Hence, we would suggest that, for the DSM to be meaningful and important for clinicians and researchers, it needs to reflect the belief that there is no tension between an externalist understanding of psychiatric disorders and the allegiance to a physicalist conception of the mental.

We should keep the psyche in psychiatry, and keep mental disorders as mental.

Declaration of Interest

None.

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