A new way of reducing the prevalence of mental disorders?

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In his lucidly written paper, Jerome Wakefield argues that a condition can be regarded as a mental disorder if a) it is considered harmful and b) it is due to a dysfunction resulting from the failure of some internal mechanism (originally destined to perform the now deranged function). This definition should hold for "physical" and for "mental" disorders. Wakefield does not distinguish disease from disorder, although the two terms are not describing the same type of conditions.

Another distinction that is important in this discussion is that between a *disorder* (and a medical disease), the expressed *needs for care* and a *sickness* (a state defined by a society as requiring treatment or deserving sickness benefits) (1).

A significant proportion of people who have a disorder do not request nor receive treatment or care; a number of people who request and receive care do not have a medically recognized disorder; and finally most societies at some point of their history designate a particular pattern of behaviour as being sick (and therefore requiring treatment or incarceration or both) although the persons concerned do not request treatment and do not suffer from any discernible disorder.

Requiring, as Wakefield suggests, that both a negative value and a dysfunction must be present to define a condition as a disorder requiring attention of the health system may lead to a number of problems. Thus, for example, people with a dysfunction that is at present not leading to a disadvantage would be excluded from treatment or care: to take Wakefield's example, people with an abnormality of corpus callosum (for example due to some infectious and curable condition) leading to dyslexia would not be offered treatment in illiterate societies, because their dysfunction does not lead to immediate disadvantages. Poor people in rich and in poor countries have often no access to many things that are available to those who are rich: would that mean that the poor should not be given health care for their dysfunctions because they will not be in situations where these might be disturbing?

I share Wakefield's faith into our capacity to assess disturbances of "mental" functions with just as much precision as that of "physical functions". On the other hand, the differences between cultures make the "negative value" assessment of a particular "factual dysfunction" so different from one setting to another that it is difficult to imagine how any comparisons of "disorders" could be done if we define them as Wakefield proposes. I therefore believe that epidemiological (and other) studies that need to work with homogenous groups should define disorders in terms of "factual dysfunction" in Wakefield's terms and then use the results of these assessments in a manner congruent with the goal of the studies – for example, to assess the prevalence of a disorder or to use them as one of the bases for the assessment of needs for care.

In summary, I think that Wakefield's analysis of the concept of mental disorder is useful, because it makes us think about the nature of diseases and their meaning, but I disagree with his conclusion that the "negative value" of a

particular dysfunction should be decisive in defining the disorder. Like in the rest of medicine, the diagnosis of a disorder should be based on well-defined symptoms indicating a dysfunction and steer clear from mixing this assessment with the assessments of social desirability or of disability.

References

1. Sartorius N. Fighting for mental health. Cambridge: Cambridge University Press, 2002.