International Review of Psychiatry

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/iirp20

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To cite this article: Awais Aftab & Mohammed Abouelleil Rashed (2021) Mental disorder and social deviance, International Review of Psychiatry, 33:5, 478-485, DOI: 10.1080/09540261.2020.1815666

To link to this article: https://doi.org/10.1080/09540261.2020.1815666

Published online: 05 Oct 2020.

INTERNATIONAL REVIEW OF PSYCHIATRY
2021, VOL. 33, NO. 5, 478–485
https://doi.org/10.1080/09540261.2020.1815666

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REVIEW ARTICLE

Mental disorder and social deviance

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ABSTRACT

Social deviance refers to actions or behaviours that violate social norms. Since the declassification of homosexuality and development of DSM-III, one of the aims of a definition of mental disorder has been to make explicit the distinction between mental disorder and social deviance. It is well-recognized that psychiatric disorders frequently manifest as violations of social norms, and the validity of the distinction between disorder and deviance has been of great interest to philosophers of psychiatry. This article provides an overview of some of the major conceptual strategies that have been discussed as a means of discriminating between mental disorder and social deviance, and the extent to which these strategies can be said to be philosophically successful. Specifically, we review DSM's definition of mental disorder, notions of dysfunctions (commonsensical, clinical, naturalist), intrinsic and socially constituted distress, disability, 3E perspectives and functional norms, and ethical and political approaches to this question. Current philosophical strategies don't offer a distinct dividing line between disorder and deviance, but they help illuminate the relevant considerations involved. It may be concluded that the distinction between disorder and deviance is not simply discovered but also negotiated between competing values.

ARTICLE HISTORY
Received 30 July 2020
Accepted 24 August 2020

KEYWORDS
Philosophy of psychiatry; ethics; politics; mad pride; naturalism; distress; dysfunction; disability; harm

Social deviance refers to actions or behaviours that violate social norms, and it has existed for as long as societies and norms have existed in human history. Social norms can be explicit or implicit, formal or informal, and violations of these norms can range anywhere from serious legal crimes to benign violations of etiquette (Goode, 2015). All societies have developed ways of managing social deviance through formal and informal means of social control. The ways in which societies exercise their power for control has received tremendous attention from philosophers, sociologists, ethicists, and criminologists, among others (Goode, 2015). Notions of "madness" and "insanity" have historically been intricately related to social deviance, and the lens of psychopathology is one of the ways by which social deviance has been viewed (Scull, 1977; Szasz, 1997).

Historical examples abound, from homosexuality to "sluggish schizophrenia" (Drescher, 2015; Merskey & Shafran, 1986). This history of "misuse" of psychiatric diagnosis appears to suggest that a society will utilise whatever tools are available to regulate violations of social norms, including the tool of disorder designation. The charge that psychiatry is an instrument of social control is an old one but was articulated perhaps most forcefully and memorably by psychiatric critics in the 60 s and 70 s (such as Thomas Szasz, R.D. Laing and Michel Foucault). In the face of these concerted criticisms, psychiatry made an organised effort to distance itself from charges that it pathologizes or medicalizes social deviance (Decker, 2013). This was in some ways a direct result of the debate surrounding the diagnostic status of homosexuality and the eventual decision of the APA—backed by a referendum of its membership—to exclude ego-syntonic homosexuality from DSM-II (Bayer, 1987). Robert Spitzer, who crafted the proposed change, primarily utilised a conceptual strategy to achieve this outcome by arguing for a definition of mental disorder that places central emphasis on the presence of distress and impairment of function (disability) (Bayer, 1987). This line of thinking was formalised in DSM III where a definition of mental disorder was offered; one of the aims of this definition was to make explicit the distinction between mental disorder and social deviance, and to emphasise

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that psychiatry does not (and does not wish to) pathologize mere conflict with society (Spitzer & Williams, 1982). However, it is well-recognized that psychiatric disorders frequently manifest as violations of social norms, and the validity of the distinction between disorder and deviance has been of great interest to philosophers of psychiatry. This article provides an overview of some of the major conceptual strategies that have been discussed as a means of discriminating between mental disorder and social deviance, and the extent to which these strategies can be said to be philosophically successful. While psychiatry in its official capacity remains committed to its ability to distinguish between disorder and social conflict (American Psychiatric Association, 2013), the philosophical verdict is more guarded, and reflects the fluid nature and fuzzy boundaries of these concepts. Although we restrict ourselves to mental disorders in this article, the problem is by no means restricted to psychiatry and is relevant to many other areas of medicine as well.

It is important here to distinguish social deviance from personal deviance, i.e. deviance from an individual's personal norms. Personal norms are strongly influenced by social norms but the two can diverge substantially. Deviations that lead to a diagnosis of mental disorder can therefore result from: (a) deviance from social norms without deviation from personal norms; (b) deviation from personal norms without deviation from social norms; (c) deviance from both personal and social norms. Much of the literature focuses on social deviance, but personal deviance is also relevant and raises different issues. For example, coercive interventions are typically not considered in cases of personal deviance as the person usually seeks help and the focus of medical care is often on pragmatic ways of assisting them regain personal and social functioning.

How central is deviance to judgments of psychopathology?

A popular understanding of social deviance views it narrowly in terms of violation of criminal, sexual, moral, or political norms. However, it is possible for our psychological lives to violate social expectations of meaningful behaviour and rationality in a variety of ways. For example, extended mourning after a loved one's death can violate social expectations of bereavement (Logan et al., 2018). Research on "folk psychiatry" suggests that judgments of psychopathology are often applied to behaviour that is deemed to be unexpected, unfamiliar, not easily intelligible, and breaks the unwritten rules of social conduct and shared rationality (Coulter, 1979; Haslam et al., 2007). If such violations fall within the umbrella of social deviance, then it would imply that the very attribution of mental illness by lay people is typically based on an initial judgement of deviance.

DSM's preventive strategy: dysfunction

DSM-5 defines mental disorder as a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour; this disturbance reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association, 2013). DSM-5 further states that mental disorders are usually associated with significant distress or disability, the latter evident in social interaction, and in occupational or other activities.

All editions of DSM from III to 5 explicitly state, with some variation of words, that deviance or conflict between the individual and society is not mental disorder per se; deviance or conflict constitutes a mental disorder *only* if it arises from a dysfunction in the individual. This is the relevant statement in DSM-5: "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." (American Psychiatric Association, 2013)

For this dysfunction-based defense to do any meaningful work in distinguishing between social deviance and mental disorder, we need to be able to define and identify dysfunction. That, however, proves to be a more conceptually difficulty task than is obvious from DSM's reliance on the notion.

Dysfunction

Despite the important conceptual role played by the notion of dysfunction, DSM never formally defines this crucial term, leaving its understanding vague and open to multiple interpretations. It is not surprising then that the authors of the DSM-5 white paper on nomenclature felt that the mental disorder definition "is not cast in a way that allows it to be used as a criterion for deciding what is and is not a mental disorder, and it has never been used for that purpose." (Rounsaville et al., 2002)

Common sense view of dysfunction

Kenneth Kendler (Vice-Chair of the APA DSM-5 Steering Committee), when asked to elaborate on the DSM meaning of dysfunction, explained it as common-sensical: "The general idea of dysfunction is common-sensical—that the relevant psychobiological system is not doing what it is supposed to do. Examples might include providing your higher centres with an approximately veridical sense of the world around you, keeping levels of anxiety roughly appropriate to the real dangers being confronted, producing mood states approximately congruent to the environmental situation, etc. DSMs have traditionally seen disorders as existing within individuals and, for example, avoided providing diagnoses for dysfunctional marriages or families. So, in that sense, the underlying disturbance is seen to exist within individuals." (Aftab, 2020)

There are two strands to this commonsensical view:

i. Similar to folk ideas, there is a sense that something has "gone wrong" and that a behaviour is not what it is supposed to be.
ii. The disturbance is "within the individual" rather than within interpersonal or social relations (although the *cause* of the disturbance may be interpersonal or social relations)

Neither strand of the commonsensical view offers much protection from inappropriate pathologization of social deviance. Consider the case of homosexuality, which was seen as (i) a failure of sexual orientation to do what it is "supposed to do," and where (ii) the locus of homosexuality is within the person. What of the aetiological view of dysfunction?

Aetiological view of dysfunction

Often in practice, *aetiology* is understood as *dysfunction* when the condition has already been designed as a disorder on the behavioural level. That is, in usual practice, the aetiological mechanisms do not determine whether the condition in question is a "disorder"; instead, the aetiological mechanisms are said to be dysfunctional based on the assumption that the clinical condition is a bona fide disorder. Such a circular approach obviously offers little philosophical guidance. What is needed is a discriminative account of what sorts of causal mechanisms or what sorts of aetiologies constitute dysfunction (Murphy, 2006). Naturalistic accounts of disorder offer a way of defining dysfunction in terms of abnormalities of "natural function."

Defining dysfunction in terms of underlying causal mechanisms requires a notion of design from which the causal mechanisms deviate. The most precise definition of this approach comes from Jerome Wakefield's Harmful Dysfunction analysis. According to Wakefield, a dysfunction is "a failure of some internal mechanism to perform a function for which it was biologically designed (i.e., naturally selected)." (Wakefield, 2007) Biological and psychological systems are designed by evolution to perform a function within a certain range. Dysfunction is the failure to live up to that design.

One of the problems with Wakefield's account is that our knowledge of the mechanisms underlying much of psychological functioning is limited, and their evolutionary history is largely speculative. In practice, this leads to the use of surface phenomena as dysfunction indicators, the presence of which implies the existence of dysfunction. First and Wakefield have reviewed strategies employed by the DSM diagnostic criteria to infer the presence of dysfunction (First & Wakefield, 2013). Such dysfunction indicators often end up relying on folk intuitions and normative comparisons which are highly susceptible to social biases. Additionally, the inference of dysfunction in the presence of dysfunction indicators is just that—an inference. It is tentative, and its validity remains to be demonstrated. In something as complicated as behavioural disturbances, it can be behaviourally clear that something has gone wrong, yet it may not be entirely clear whether it reflects a mechanism failure or failure of some other sort (such as design/environment mismatch) (Schwartz, 2017).

The practice of psychiatry makes little use of dysfunction

Perhaps one of the most telling practices is the use of *other specified* or *unspecified* disorders (what used to be called *not otherwise specified*). Even when symptom presentations do not satisfy DSM thresholds of dysfunction indicators, the accepted practice is to label them as *disorders* and prescribe treatment for them if this is felt to be clinically warranted (Aftab, 2019a). For instance, if a person presents to a psychiatrist with depressive symptoms that do not meet criteria for major depression, the presentation is usually labelled as "other specified depressive disorder" if the patient finds the symptoms distressing. DSM clearly sanctions the disorder designation when there is

insufficient evidence of dysfunction, even by its own indirect inferential standards. If we were to ask the practicing psychiatrist, we would find that she is hardly concerned with this abstract question of failure of natural design. What the psychiatrist will assess is the degree of distress and disability. If the degree is judged to warrant treatment, the psychiatrist will call it a *disorder* (Aftab, 2019a).

This also suggests that in clinical practice there is less emphasis on the distinction between dysfunction and distress/disability. This is because the presence of distress/disability is seen as an indicator of dysfunction, and more generally, dysfunction is often understood in terms of distress and disability. Wakefield arrived at a similar conclusion based on textual analysis of DSM-III-R's definition of mental disorder: "It may be concluded that the dysfunction clause is not intended to play a substantive role in the definition because its content is thought to be exhausted by the kind of distress and disability specified." (Wakefield, 1992). Is it possible to distinguish social deviance from mental disorder through the concepts of distress and disability?

Distress

Rashed and Bingham (2014) have argued that distinguishing social deviance from mental disorder requires distinguishing between phenomena that are distressing owing solely to social conflict and discrimination from those that are "intrinsically" distressing. Given the metaphysical difficulties in establishing a satisfactory philosophical account of "intrinsic" as it applies to mental disorders, Rashed and Bingham instead develop the notion of "socially constituted distress." Accordingly, they state that conditions in which distress is socially constituted should be excluded from candidacy for mental disorder (Rashed & Bingham, 2014). Distress is socially constituted when it arises through the acceptance and internalisation of negative, demeaning values and perceptions prevalent in society as pertaining to traits and inclinations that a person identifies in himself. This generates a state of dissonance of the form "I desire y/I should not desire y" or "I am x/I should not be x," where the latter element is internalised based on negative social characterisations.

Such a formulation of distress can easily be understood using the example of ego-dystonic homosexuality. In such cases, the individual is distressed at recognising their sexual attraction to members of the same gender, but this distress results from an internalisation of negative social attitudes towards homosexuality. Once appropriate social change has taken place, and "reconstructive cultural semantics" (Radden, 2012) have led to a transformation of social narratives, the dissonance and the distress might disappear. Social action therefore is envisioned as the primary level of intervention to address socially constituted distress. There are obvious situations where a society will have good moral reasons not to change, particularly where harm to others is involved in the form of paedophilia or antisocial personality.

The limitation for such an account is that there will be instances where it will not be clear whether distress is a result of internalised social disapproval in the sense envisioned by Rashed and Bingham. Consider the case of hypoactive sexual desire disorder. How much of distress associated with low sexual desire is a direct result of the low sexual desire, and how much of it is due to our contemporary social norms that place a high emphasis on the need for an active sexual life (Aftab et al., 2017)? There is reason to suspect that it is a mixture of both: even in communities permissive of asexuality, a loss of sexual desire may nonetheless be distressing to the individual. Yet, at the same time, many who experience distress at their loss of sexual desire in contemporary Western societies may not be distressed if social attitudes were different.

This limitation is further highlighted by the distinction between social deviance and personal deviance, which we cited earlier in this review. While a focus on "intrinsic distress" addresses the issue of social deviance, the issue of personal deviance is left largely untouched. Consider the scenario of an individual who is distressed and impaired by their own account (i.e. personal deviance with or without social deviance), and let's imagine that the distress is not socially constituted. It becomes apparent on reflection that this by itself is not sufficient for the designation of disorder. The individual may be distressed or disabled but may conceptualise this difficulty in terms of a religious/spiritual challenge or as a moral lapse (e.g. addiction). They may understand the issue as part of their identity (e.g. mood alterations in bipolar disorder), as part of the aging process (e.g. mild cognitive impairment), or as wholly socially generated.

Disability

Distinguishing social deviance from mental disorder through recourse to the concept of disability lands us in similar problems to the ones we encountered with

the concept of distress. We can understand disability as individual traits associated with limitations in personal and social functioning. For example, a heightened sense of anxiety, extreme mood changes, and hearing voices can all be associated with various limitations. Given this definition, we could argue that only if those limitations are intrinsic to the traits in question should these traits be considered for mental disorder candidacy; conversely, limitations that are a consequence of a social or physical environment that fails to accommodate diverse variations in traits and behaviours should not be considered for mental disorder candidacy. The key point, then, is to determine if the traits in question are intrinsically disabling. What sense can we impart to this notion?

The first possible interpretation of "intrinsic disability" can go like this: we know that the trait is disabling in this environment, and what we want to determine is whether this disability is intrinsic or socially generated. The former condition would be satisfied if the trait is disabling in all possible social environments. If it is, then we can surmise that the limitations experienced by individuals with these traits are not caused by social discrimination and oppression, since we cannot imagine a social environment in which they would not be disabling. Another way of making the same argument is to say that even if all stigma and discrimination were eliminated, the traits will remain disabling. Alison Jost (2009), for example, makes this point by drawing a distinction between conditions that are disabling because of an unaccommodating physical and social environment and conditions that are "inherently negative" and "will always cause suffering" even if stigma and disadvantage were to be eliminated (see Rashed, 2019, p. 29).

As it stands, this sort of argument amounts to a restatement of the intuition behind the notion of "intrinsic disability" rather than a solution to our problem (distinguishing social deviance from mental disorder). We are still left with no purchase over how to determine if a trait satisfies this notion. How can we know if a trait would remain disabling after all stigma and disadvantage are eliminated? What does it mean to eliminate all stigma and disadvantage and how will we know that we've achieved this? And are we really unable to imagine *any* environment where, say, the traits of "bipolar disorder" cease to be disabling? The counterfactual nature of this interpretation renders it unhelpful in defining a useful notion of intrinsic disability.

Another possible interpretation of "intrinsic disability" can trade on the notion of natural function. Within this view, a trait is intrinsically disabling if we can demonstrate that it involves a failure of natural function, i.e. a dysfunction, and not a failure of societal inclusion and adjustment. But we have already seen the problems with this sort of argument, for it requires that we define dysfunction, which is the very thing that we were trying to get a handle on through the concept of disability. Accordingly, this interpretation of "intrinsic disability" cannot help us either.

Putting aside these two possible interpretations and their shortcomings, there is a more fundamental problem with the notion of "intrinsic" disability. The very notion of disability implies a social and environmental context in which the actions in question are thwarted. Any specification of the disability will have to appeal to that context as well as to the individual traits. Disability is a product of the interaction between context and traits, and so the notion of "intrinsic" disability—as in, disability where the social context can be fully subtracted—does not work conceptually.

We can therefore conclude that there is no straightforward way for distinguishing social deviance from mental disorder through recourse to the concept of disability.

3E perspectives and functional norms

In recent years 3E cognition (Enactive, Embodied, and Embedded) perspectives on psychiatric disorders have gained traction, and the application of this framework to psychiatry is being fleshed out in great detail (De Haan, 2020; Nielsen & Ward, 2020). The embodied, embedded, and enactive perspectives do not assume any divide between the natural and normative components of mental disorder. From a 3E perspective, disorder designation is a normative claim but the norms in question are not sociocultural norms but rather functional norms of an individual that support her continued self-maintenance and adaptation. Since the functionality of a behaviour is contingent on the social environment as well as the individual's understanding of well-being and flourishing, the distinction between norms that serve the individual's continued self-maintenance and adaptation and norms that serve society is challenging to make.

In principle the 3E approach can maintain that "functional norms of individuals that are derived from non-functional or arbitrary socio-cultural norms should not play a role in demarcating disorder" (Nielsen & Ward, 2020). While in hindsight this may

reasonably apply to conditions such as homosexuality, the distinction is much harder to make in situations where social norms may have been internalised by individuals themselves as their functional norms (for instance, in the past when at least some homosexual individuals were distressed by their orientation and genuinely believed that they were suffering from a disorder and sought help for it). When it comes to our psychological lives, the notions of self-maintenance and adaptation are not currently operationalised in a manner that would allow us to resolve controversial cases with any degree of consensus.

Ethical and political approaches

The inability of naturalist theories to distinguish mental disorder from social deviance in psychiatric practice has prompted an interest in ethical and political approaches to this problem.

One approach, termed "ethical validity" of disorder designation (Aftab, 2019b), involves balancing considerations of alleviating distress and disability, and considerations of harm caused by disorder designation. Harm caused by disorder designation includes all the ways in which disorder designation prevents individuals from flourishing in a manner available to those without a disorder designation. This includes imposition of sick role, social discrimination and stigmatisation, production of self-guilt and self-doubt in the individuals, unnecessary—possibly coercive—treatment, and barriers to progressive social change.

Powell and Scarffe, while they do not argue exclusively for an ethical approach, argue for the need for "moral objectivity" as a component of disorder designation, which requires that our reasons for disvaluing a given dysfunction are subject to rational justification (Powell & Scarffe, 2019). They point out that prior normative accounts of disorder have relied too heavily on relativistic societal value judgements and they argue that what is needed instead is a philosophical view according to which moral norms can be objectively justified (if one does not subscribe to moral skepticism). They acknowledge that the methods of moral justification are contested, and they do not specify details of what constitutes rational moral justification. However, they suggest that the moral reasons presented in justification of disorder designation must go beyond religion and tradition, must not be arbitrary or bigoted, must not be based on false empirical claims, and must be subject to critical scrutiny and revision. For example, on their account, to conclude that homosexuality is not a disorder, one would have to argue that disvaluing homosexuality is not rationally justified and that doing so causes objective harm and injustice. They characterise their emphasis on rational moral justification as "thick normativity" in contrast to "thin normativity" which simply relies on social values (Powell & Scarffe, 2019). Their account, however, ultimately leads them to the discussion of individual prospects for flourishing in an unjust social environment, and they recognise that there is a tension between acting to promote individual flourishing and combating social injustice: "Precisely how this tension should be resolved in medicine is unclear, and reasonable people may differ on this matter." (Powell & Scarffe, 2019)

Sadler et al. (2009) discuss their bioethical approach in the context of the larger issue of medicalisation, of which disorder designation is one specific instance. Using the example of ADHD, they argue that if the analysis of metaphysical assumptions fails to determine whether ADHD is better understood as a "disorder" or as an "individual difference which must be accommodated," then this situation requires a higher-level argument based upon a theory of the good society or *eudaimonia*. They go on to discuss how a libertarian account of a good society might contrast with a liberal account in handling this question, and while they do not arrive at a conclusive answer, they point out that "this style of analysis for public policy purposes can find room for common ground among frequently-opposed political groups like libertarians and liberals" (Sadler et al., 2009).

Other approaches emerge from consideration of activism in mental health, such as Mad Pride and neurodiversity (see Rashed, 2019 and Chapman, 2020). Both approaches question the very distinction between social deviance and mental disorder. With some strands of Mad Pride, the concept of mental disorder as such is rejected, and diagnostic categories are taken up as components of a person's self-understanding or identity. So conceived, there is no category of mental disorder that we ought to carefully designate. And with some strands of neurodiversity, while existing psychiatric categories might be accepted, their characterisation as "disorder" is rejected in favour of viewing these traits as components of human diversity or difference.

As is typical for philosophy, these bioethical and political approaches often do not lead to conclusive answers—and therefore don't offer a distinct dividing line between disorder and social deviance—but they illuminate the relevant considerations. They highlight the importance of the rational justification of ethical

deliberations and the political dimensions of disorder designation. By doing so they emphasise that the distinction between disorder and deviance is not simply discovered but also negotiated between competing values and interests.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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