

Doctors without 'Disorders'

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DOCTORS WITHOUT 'DISORDERS'

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Abstract

On one influential view, the problems that should attract medical attention involve a disorder, because the goals of medical practice are to prevent and treat disorders. Based on this view, if there are no mental disorders then the status of psychiatry as a medical field is challenged. In this paper I observe that it is often difficult to establish whether the problems that attract medical attention involve a disorder and argue that none of the notions of disorder proposed so far offers a successful demarcation between medical and non-medical problems. As an illustration, I consider why delusions are considered pathological and whether they attract medical attention in virtue of being pathological. Although there are several promising answers to what makes delusions pathological, available accounts of the pathological nature of delusions fail to distinguish delusions from other irrational beliefs that are not typically thought of as pathological; and cannot explain why delusions typically attract medical attention whereas other irrational beliefs do not.

I. Medical problems or problems in living?

In his paper on the diagnostic implications of the concept of mental disorder, Jerome Wakefield starts with a question and a statement: “What do we mean when we say that a mental condition is a medical disorder rather than a normal form of human suffering or a problem in living? The status of psychiatry as a medical discipline depends on a persuasive

answer to this question.” (Wakefield 2007, page 149). It is Wakefield’s statement that I intend to put pressure on. I will suggest that the notion of disorder is not central to the project of establishing the status of psychiatry. There is no available notion of disorder which makes sense of the scope of medical practice, mainly because medical attention and medical care are appropriate responses to a variety of problems people experience, independently of whether we identify such problems as disorders.

The belief that the notion of disorder is key to establishing what deserves medical attention and medical care comes from the idea that the primary goal of medicine is to prevent and treat disorders. This narrow conception of medicine has had disastrous consequences for the status of psychiatry. The distinction between the pathological and the normal can be a challenge for the whole of medicine; yet it is psychiatry whose diagnostic framework has been most harshly criticised as a result of acknowledging how blurred the distinction is and how challenging it is to determine whether any given outcome is the result of a dysfunctional or disordered process. The purpose of the paper is to argue that the answer to what counts as pathological (or disordered) does not always work as an answer to what deserves medical attention.

In the first part of the paper, I address some concerns about leaving ‘disorder’ behind in the project of establishing the scope of medical practice in general. If ‘disorder’ stops playing its demarcation role, how do we solve disputes about what problems should be medically treated and in what conditions behaviour may be excused? Instead of getting rid of ‘disorder’ altogether, cannot we give up hope of providing a precise definition and settle instead for *some idea of* disorder? In the second part of the paper, I focus on the distinction between the normal and the pathological as applied to delusions. It is hard to provide a coherent answer to what makes delusions pathological which also explains why delusions are typically the appropriate target of medical attention. This suggests that, in future research, we should explore the view that the nature of the problems we experience does not determine how we respond to those problems in isolation from considerations about our goals and interests, as individuals and as societies. The thesis that the status of medicine is not compromised by our incapacity to arrive at a coherent notion of disorder can help us make progress with a range of debates about the role of medicine in society.

II. The ‘disorder’ wars

Traditionally, medicine has been linked to the promotion of health, understood both (negatively) as an absence of illness and (positively) as a state of wellbeing. Consider as a starting point the goals of medicine identified by the *Hastings Center Goals of Medicine* project: (1) the prevention of disease and injury and the promotion and maintenance of health; (2) the relief of pain and suffering caused by **maladies**; (3) the care and cure of those with a malady and the care of those who cannot be cured; and (4) the avoidance of premature death and the pursuit of a peaceful death (Anderson 2007). The four goals capture what most people are likely to intuitively believe about medical professionals, that their job is—to put it crudely—to keep us alive and pain-free.¹ But we sometimes seek the help of medical professionals when we have a problem that we believe would benefit from their expertise, without asking ourselves in advance whether our problem is a disorder. Or do we? Doesn’t it all depend on how we define ‘disorder’?

Naturalist models see disorders primarily as deviations from normal functioning, and often as dysfunctions in a biological sense (Boorse 1975; Matthewson and Griffiths 2017). **On** the naturalist framework, there is an attempt to keep the concept of disorder value-free as far as possible, and to assume that disorders are located within the individual’s personal boundaries. Normativist models understand disorders primarily as disvalued states, where the state is disvalued because it harms the individual or constitutes a disadvantage for that individual (Reznek 1987; Cooper 2002). The normativist framework reacts to naturalist models by rejecting the idea that disorders are value-free and proposing that what counts as a disorder depends on human interests. Accounts that combine naturalist and normativist intuitions about disorders, such as Wakefield’s, hold that a state needs to be a deviation from the norm *and* to be disvalued in order to count as a disorder. Although the three

¹ In his textbook on the philosophy of medicine, Alex Broadbent (2019) maintains that “the goal of medicine is to heal the sick, but the core business of medicine is to understand and predict health and disease” (pp. xvii and xviii). In their introduction to the philosophy of medicine, Paul Thompson and Ross Upshur (2018) distinguish clinical practice and clinical research. Clinical practice is defined as “the activities of diagnosing, treating and preventing disease” (pp. 11-12). In this paper, I focus on medical practice and do not directly address the role of disorder in medical research.

models develop different views of disorder, they tend to agree that the notion of disorder is key to understanding and demarcating medical practice.

As argued persuasively in the literature, both naturalist and normativist approaches to disorders have limitations (Murphy 2015). Naturalists struggle to find a scientifically respectable account of abnormal human functioning. Normativists cannot easily distinguish between problems that should be medicalised and problems that should not. The same fate befalls alternative ways of establishing what medical practice should be about, where failures of health are seen as obstacles to happiness, good functioning, or moral agency. On those views, health is not about well-functioning or malfunctioning *organs* or *sub-systems in the body*, but about *persons*, and more specifically about the person's agency, values, and goals (Bolton and Gillett 2019, chapter 4; Galderisi et al. 2015; Nordenfelt 2001)

Coming up with necessary and sufficient conditions for 'disorder' is an extremely challenging feat if the notion of disorder is expected to play a key demarcation role, because medicine does all of the following: it deals with malfunctioning organs and debilitating conditions; offers solutions to some of the problems we experience, such as insomnia and weight gain; and supports our capacity to make a contribution to society, achieve our goals, and respond with resilience to adverse circumstances. The variety of purposes medical practice serves cannot be easily subsumed under the general goal of preventing and treating disorders. Cannot we just reject 'disorder', then, as the key notion for demarcating medical from non-medical problems?

III. 'Disorder' as a demarcation criterion

Some philosophers recognise the appeal of the view that we do not need 'disorder' to settle questions about medicine—the view sometimes called 'eliminativism' (Stegenga 2018). But they also think that we suffer a potential loss if we are not able to appeal to a general notion of disorder because we cannot explain why certain conditions have certain characteristics that are of special interest to us.

If it were possible to produce an adequate conceptual account of disorder one might hope that this account would help shed light on at least some broader conceptual issues concerning our thinking about disorder. For example, a satisfactory account of disorder might be hoped to elucidate why it is that we tend to think that disorders can excuse and deserve treatment, for example. It might help shed light on the question of whether

medics should properly be considered authoritative in determining who suffers from a disorder, and whether they have been cured. (Cooper 2020)

Without a notion of disorder, how would we explain that some conditions but not others excuse behaviour? How would we account for the fact that some conditions but not others deserve treatment? It would be neat to be able to claim that the conditions that excuse behaviour and the problems that are medical all share some basic features that make up our preferred notion of disorder. However, making decisions about the excusability of a person's behaviour or the appropriateness of treatment based on diagnosis may be at the same time intellectually misleading and ethically suspicious.

Take schizophrenia, which is considered as a mental disorder. In some cases, it excuses behaviour that violates moral norms, in other cases it does not. This suggests that when some conditions excuse behaviour, they do not do so just in virtue of being disorders, but in virtue of compromising in the relevant individual whatever capacity is required for people to be able to conform to the moral norms at hand (see e.g., Broome et al. 2010). Take a young man, Bill, who erroneously believes—due to hallucinations and delusions—that his neighbour engages in threatening behaviour towards him. Bill may not be excused for assaulting his neighbour because, while it is true that Bill's having hallucinations and delusions *explains why* Bill feels threatened, and the perceived threat explains his hostility towards the neighbour, surely the acceptable course of action for Bill would be to try and sort out differences peacefully with the neighbour or involve the authorities, instead of resorting to violence. Bill's experiences may explain the assault but they do not excuse it; and thus Bill is still responsible for the assault. A slightly modified scenario may change our intuitions about whether Bill is responsible, for instance if the hallucinations or delusions experienced by Bill make it impossible for him to respond to the perceived threat from the neighbour in a non-violent way.

Questions about a person's responsibility in cases of poor mental health should be answered based on whether agency is compromised—e.g., does Bill's schizophrenia compromise his capacity to make decisions and to understand the consequences of those decisions? People with one diagnosis may be held morally responsible for their actions in some circumstances and excused on accounts of insanity in other circumstances because their agency is not always affected to the same extent. When generalisations are made on the basis of the person's diagnosis alone, these are acknowledged as imperfect shortcuts for more nuanced judgements that would ideally take into account individual differences, the nature of the

environment, and other contextual factors—such as what the alternative options to the person’s chosen course of action were (Bortolotti et al. 2014; see also Jefferson and Sifferd 2018 on psychopathy and responsibility).

What about the utility of ‘disorder’ in regulating what conditions we should respond to with medical treatment? We know that experiences that are fairly common and debilitating (e.g., prolonged lower back pain) can be addressed in different ways ranging from no intervention (waiting for the condition to improve on its own), pain relief, surgery, and physiotherapy, depending on the effects of the experience on the person’s functioning. Several factors may influence the decision-making process, but often it is not possible to rely on whether the problem is a disorder in the sense that it arises from a dysfunction. That is because there may be uncertainty about what causes the symptoms. The NHS information sheet on lower back pain explains that the experience can be caused by a strain, a slipped disc, or sciatica, and adds that “often it's not possible to identify the cause of back pain” (NHS 2017).


More generally, even when epistemic problems do not arise, the appropriateness of treatment and the heterogeneity of treatment options for people with the same undesirable condition are not exclusively determined by whether the condition can be labelled as a disorder. Not all the people who receive medical treatment have a disorder (in either the naturalist or normativist understanding of disorder)—as in the common examples of medical care for pregnancy or lifestyle interventions—and not all people who have a disorder (in either the naturalist or normativist understanding of disorder) receive medical treatment—a classical example of a biological dysfunction, toe fusion, does not require intervention unless it impairs mobility, nor do some chronic conditions such as gum disease for which there is no effective treatment. A normativist like Cooper could probably explain such cases: toe fusion is not a disorder unless it is bad for the person who has it, and gum disease is potentially (if not currently) treatable. However, a condition that does not impair functioning like toe fusion could still be bad for the person who has it due to the negative social responses to it, and treatability in principle is a notion that needs tidying up to avoid becoming too permissive. If a face perceived to be ugly in some cultural context causes harm to the person and can be ameliorated by plastic surgery, would the normativist be comfortable in calling it a disorder?


Abandoning the centrality of the notion of disorder may seem a radical solution. **Couldn't just** give up the project of providing a *precise definition* of disorder and just offer *some idea* of what disorders are? Maybe ‘disorders’ is a family resemblance term, just like ‘games’.

Germund Hesslow argues that we do not need a set of necessary and sufficient conditions for disorder to understand what medicine does:

Diseases are to the clinicians what gardens are to gardeners or cars to garage mechanics.

These terms are handy to point to a certain area of competence, but the gardener does not need a definition of 'garden' to help him decide what to do about plants on a balcony and the garage mechanic does not need a definition of 'car' to be able to decide if he should try to fix a lawnmower. (Hesslow 1993, p. 13).

The reason why garage mechanics can fix lawnmowers is not that lawnmowers are cars but that the expertise of mechanics is such that it extends to the fixing of things that are not cars but are relevantly similar to cars (e.g., have engines or have wheels). Thus, we do not need a definition of disorder that encompasses cancer, panic  acks, and toe fusion to establish the scope of medicine as a practice, but **simply acknowledge** that the conditions have overlapping similarities without sharing a common feature.

I doubt this would help, though. If the issue is that treating and preventing disorders does not exhaust what medical professionals can help us with, we need neither *a precise definition of disorder* to know what medicine does, nor *an idea of disorder*. We often seek medical expertise for a perceived problem and receive medical care to address and possibly solve that problem. Neither of these activities (seeking medical expertise or receiving medical care) relies on the problem being a disorder within a naturalist, normativist, or a harmful dysfunction account of disorder. One suggestion is that, if I cannot sleep well and the lack of a proper rest negatively affects my capacity to do what I wish to do (e.g., complete house renovations) or to play an active role in society (e.g., be alert at work and take care of my kids), **medical  ntion and medical care are appropriate whether or not my insomnia qualifies as a disorder.**²

² Obviously, there are practical concerns in societies with limited resources: which problems should be prioritised when the capacity for medical attention and medical care is constrained? We can acknowledge the need for a principled way to prioritise problems without committing to the view that the problems identified as disorders should be prioritised. In the picture I am sketching, something need not be a disorder to qualify either as a medical problem or as a *serious* medical problem.

IV. What makes delusions pathological

Next, I want to offer an illustration of the difficulty in arriving at a coherent picture of what makes a problem pathological, and of the fact that judgements about whether a problem is pathological rarely reflect pre-theoretical judgements about whether the problem should receive medical attention and care.

The label ‘pathological belief’ is not supposed to pick out those beliefs that people with a pathology happen to have, but beliefs that either are signs of a pathology or are caused by a pathology. Often, though, beliefs are simply described as pathological when they deviate from some norm to which they are expected to conform. There is great heterogeneity both in what people mean by ‘pathological’ when they use the label to describe a belief, and in the explanation of the pathological nature of beliefs. This is consistent with the previously observed heterogeneity in the uses of the term ‘disorder’ and in the explanation of what counts as a disorder. As the most obvious and agreed-upon example of beliefs that are pathological in the philosophical and psychological literature is that of clinical delusions, next I shall review the most influential proposals of what makes delusions pathological.

Delusions are caused by a dysfunction of belief-fixation or belief-maintenance.

In parallel with the debate about disorder, *naturalists* about the pathological nature of delusions agree that whether a belief is pathological depends on whether the belief’s aetiology involves a dysfunction. The claim is that in pathological beliefs there is something wrong in the mechanisms responsible for how the beliefs are formed or maintained. In some characterisations of delusion formation, the words ‘deficit’ and ‘dysfunction’ are indeed used:

[W]e advocate a deficit model of delusion formation, that is, delusions arise when the normal cognitive system which people use to generate, evaluate, and then adopt beliefs is damaged. (Langdon and Coltheart 2000, p. 184)

[T]he pathological character of delusions arises from an executive dysfunction in a subject’s ability to detect relevance in the environment. I further suggest that this dysfunction derives from an underlying emotional imbalance—one that leads delusional subjects to regard some contextual elements as deeply puzzling or highly significant.

(Petrolini 2017, p. 502)

On the naturalist reading, delusions are pathological because of their aetiology, and the nature of the deficit or dysfunction can differ considerably depending on the preferred theory of delusion formation. Here are just some of the options proposed in the literature about the sort of deficit or dysfunction that could be responsible for the abnormality of delusions: on empiricist accounts of delusions, where the delusion is seen as an explanation for the person's experience, the problem lies in either the perceptual anomaly to be explained (Maher 1974), or in the perceptual anomaly in conjunction with **either** reasoning biases (e.g., Fine et al. 2007; Langdon et al. 2010) or reasoning deficits (e.g., Langdon and Coltheart 2000; Coltheart 2007). In predictive coding accounts of delusions, where there is no neat distinction between perception and belief, aberrant prediction-error signalling--which causes disruption to attention and automated learning--is responsible for the delusion being formed and maintained (Corlett 2018). Alternative accounts (often called 'multidimensional') stress the role of emotional imbalances and other failures in cognition and social cognition in the formation or maintenance of delusions (Freeman et al. 2019).

This is not the place to compare and evaluate the merits of competing delusion-formation theories, but we should acknowledge that it is a challenge for any aetiological story to account for the features of different types of delusions, and there is an epistemic issue too: it is not always clear to what extent the source of the problem is a deficit or a dysfunction as opposed to another type of failure. In one-factor and predictive coding theories, one could argue that there is something amiss in the process leading up to the fixation of the belief, but it is not obvious that this anomaly makes the delusion itself pathological. In Maher-style accounts, there is an unusual experience requiring an unusual explanation and the delusion may well be the best way to explain the unusual experience; in Corlett-style accounts, there is a disruption of prediction-error signals that needs to be 'tamed' for automated learning and attention to resume, and the delusion is an adaptive response to the disruption. On such accounts, delusions can be seen as an imperfect solution to the problem rather than the problem itself.

In two-factor theories advocating reasoning *biases*, people reporting delusional beliefs are found to reason *differently from* people who do not, but the difference is not a disadvantage independent of the context in which the bias operates, and need not count as a deficit or a dysfunction—indeed, the whole point of describing the difference as a bias is to avoid the implication that a deficit is involved. For instance, people with schizophrenia are more vulnerable than controls to a jumping-to-conclusion bias (they need fewer items of evidence to reach a decision in conditions of uncertainty), but are also less vulnerable to a statistically

normal but irrational tendency to gamble when faced with a certain loss (Brown et al. 2013). This suggests that the presence of biases in the belief fixation process is not sufficient for the resulting belief to qualify as pathological, and indeed many non-pathological beliefs (such as the self-enhancing beliefs studied by social psychologists) are the output of (optimistically) biased reasoning (Taylor 1989).

In two-factor theories advocating a *reasoning deficit* or a *doxastic dysfunction*, there is a problem identified as a deficit or as a dysfunction, such as the failure for the belief-fixation system to inhibit implausible hypotheses or to revisit the adoption of a belief that is being disconfirmed by further evidence. However, the presence of the deficit or dysfunction may not be sufficient for the belief to count as delusional, or even as pathological. The second factor in two-factor theories features has been advocated in the explanation of other beliefs (McKay et al. 2005), including delusions that are not explanations for anomalous experiences (*motivated delusion*); non-delusional beliefs that regarded as symptomatic of some mental disorder characterised by memory impairment (*confabulation*); and wide-spread beliefs in the non-clinical population that emerge due to biased handling of the evidence (*self-deception*). This suggests that the involvement of the cognitive deficit alone cannot help us tell apart either delusional beliefs from non-delusional beliefs, or beliefs that affect only the clinical population from beliefs that are common in the non-clinical population.

In sum, there is an intuitive answer to the question what makes a belief pathological on naturalist grounds: a belief is pathological when a deficit or dysfunction affects its fixation or maintenance processes. However, when we consider the most influential aetiological accounts of delusions, there is no deficit story that vindicates the distinction we make between delusional and non-delusional beliefs, and between pathological and normal beliefs. More central to our purposes here, if the same deficits affect people who report delusions and people who are self-deceived, the judgement about which beliefs are pathological based on those deficits does not give us good reason to determine which beliefs should come to the attention of healthcare professionals. Isn't how the beliefs affect the person's functioning that drives medical concern?

Delusions have troubling surface features.

It is often difficult to establish whether a belief is pathological based on the mechanisms responsible for the fixation or maintenance of the belief. That is because we do not know exactly how healthy cognition works. Thus, the pathological nature of a belief may be

inferred from surface features of the belief. This is true of how delusions are defined in psychiatric manuals (e.g., see APA 2013). In the case of delusions, surface features include incorrigibility, un-understandability, subjective certainty, bizarreness of content, and responsiveness to medical intervention.

Pathological irrational beliefs are distinguished from non-pathological ones by considering whether their existence is best explained by assuming some underlying dysfunctions. The features from which to infer the pathological nature of irrational beliefs are: un-understandability of their progression; uniqueness; coexistence with other psycho-physiological disturbances and/or concurrent decreased levels of functioning; bizarreness of content; preceding organic diseases known to be associated with irrational beliefs; treatment response to medical intervention, etc. (Sakakibara 2016, p. 147)

The three signs that clinicians use to diagnose delusions (incorrigibility, subjective certainty, and incomprehensibility) are better pointers to the nature of these pathologies than are textbook definitions. Incorrigibility refers to the rigid persistence in the face of rational counter-argument. Subjective certainty concerns the quality of self-evident truth with which delusions are espoused. Incomprehensibility can be “sheer” or “contextual”.

(Langdon 2009, p. 527)

The problem with taking the surface features of delusions as the reason for their being pathological is that such features are neither exclusive to delusions, nor do they apply to all delusions. Let’s start from the feature that is thought to be the most distinctive, fixity or incorrigibility. Delusions can indeed be fixed, in the sense that they are rarely dismissed when counterevidence become available. This should not be overestimated though—people with delusions vary in terms of how convinced they are of the truth of the content of their beliefs, and in some cases can develop a critical stance towards their delusional belief. The main point is that other beliefs that are not regarded as pathological, such as prejudiced beliefs or political beliefs, are also extremely resistant to change and often insulated from counterevidence. Thus, fixity seems to be neither a distinguishing feature of delusions, nor of pathological beliefs more generally.

Two features more convincingly singling out delusions from other irrational beliefs are their alleged un-understandability and so-called ‘bizarreness’: however, recent research suggests that the content of most delusional beliefs, as bizarre as it may appear at first, can be understood in the context of the person’s experiences prior to the formation of the delusion and often has some meaningful connection to actual past events that were upsetting for the person (Gunn and Bortolotti 2018). Although some delusions definitely

have a bizarre content (“My husband has been replaced by an impostor”, “I am dead”, “I have a nuclear reactor inside me”, “Barack Obama is in love with me”, etc.), other delusions are mundane (“My wife is having an affair”, “I am an underrated genius”, “My colleagues at work hate me”) and we would not be able to distinguish them from ordinary beliefs based on their content alone. Making the pathological nature of delusions hostage to bizarreness of content or un-understandability would require a revisionary stance, as there are beliefs that we do not consider delusional or pathological that have bizarre content and are sometimes difficult to understand, such as alien abduction beliefs, beliefs about direct religious or out-of-body experiences, and conspiracy theories. Once again, neither bizarreness of content nor un-understandability can help us explain why delusions typically attract medical attention.

Delusions cause harm.

In parallel with the debate about disorder, *normativists* about the pathological nature of delusions agree that judgements about whether a belief is pathological would ideally be based on whether the belief causes harm or leads to undesirable consequences for the agent, such as impaired functioning, loss of agency, and negative emotions. It is plausible to claim that delusions (differently from many irrational beliefs) negatively affect a person’s well-being causing impaired functioning, and social isolation and withdrawal (see Garety and Freeman 1999 for a multidimensional account of delusions, and Bolton 2008 for a harm-related account of mental illness in general). The normativist view is appealing because it captures **the** distinction between delusions and other, non-delusional, irrational beliefs in terms of **their** effects of having the belief on a person’s psychological and social functioning.

However, there are some qualification to make. For a belief to be pathological, we would expect the belief itself to be harmful. But is the delusion the cause of the harm or a response to a situation that is already critical for the person? The difficulty for normativism here is that often what we know about so-called pathological beliefs does not enable us to determine whether the harm is something that is caused by having the beliefs, something that is caused by something else but ultimately explains why the beliefs are adopted or maintained, or something that happens alongside the adoption and the maintenance of the belief. For instance, on some accounts of delusions in schizophrenia, the delusion is a response to the uncertainty caused by hypersalient experience and the effects **of** forming the delusions need not be worse than (but are just different from) the effects of **prolonging** hypersalient experience. When we consider motivated delusions, such as anosognosia or

Reverse Othello syndrome, their formation can be seen as a reaction to a physical or psychological trauma the person experienced. The adoption of the delusion is usually linked to a psychologically adaptive function—and can even have some short-term clinical advantages. In those cases, the delusion seems to be a response to a harmful event. Although the adoption of the delusion itself may be a source of further harm, it has adaptive features that need to be taken into account.

It is not obvious that all delusions cause harm. Some delusions such as delusions of reference or grandeur, where the person comes to think of herself as having an important mission or as having a talent that is unfairly dismissed by others, are found to contribute to the person's sense that her life is meaningful and that it is in her power to achieve something significant (examples can be found in Jackson and Fulford 1997 and Hosty 1992). In the philosophical, psychological, and psychiatric literature there have been recent explorations of the idea that some delusions may be adaptive in some sense (Lancellotta and Bortolotti 2019), psychologically (McKay and Dennett 2009), biologically (Fineberg and Corlett 2016), and even epistemically (Bortolotti 2016). In addition, relying on notions of harm to explain why delusions are pathological can be problematic, since it is possible for some people to live with the delusion in a way that is in some respect preferable to abandoning the delusion. **Ceasing after many years to believe that one is a famous TV broadcaster and starting to accept that one has been mentally unwell instead can be very disruptive and cause low self-esteem, potentially leading to depression and suicide.**

There are cases in which unquestionable harm is associated with believing the delusional content (e.g. when the content is distressing or causes guilt, fear, and anxiety). There are also cases in which it is not always clear whether the harm is caused by the person having the belief or by the reaction of the person's social environment to the person reporting the belief: individuals whose beliefs have similar surface features may experience drastically different responses, from support from their immediate social circle to isolation and exclusion.

In sum, there is an undeniable association between having delusions and experiencing harm, although it does not need to be the case that overall functioning is impaired by the delusions. However, the harmfulness condition does not deliver a clear verdict as to whether delusional beliefs in general are pathological. Having the belief may be associated with harm because the belief is a response to a critical situation or because reporting the belief leads to stigma which causes harm. On the harm-based account, it is a genuinely open question whether some delusions are pathological. The harm-based account fares better than the

naturalist account in helping us establish what beliefs need medical attention: the presence of harm does seem a sufficient reason for seeking help from medical professionals, and this applies both to delusional beliefs and other beliefs associated with experiencing harm.

However, if the presence of harm is sufficient for the purpose, it would appear that we do not need a further judgement that the belief is pathological to justify the appropriateness of medical intervention.

Delusions are harmful malfunctioning beliefs.

What would happen if we combined the insights of the naturalists and the normativists, and argued, in parallel with Wakefield's position in the disorder literature, that delusions are pathological due to their being harmful malfunctioning beliefs? Kengo Miyazono (2015) proposes such an account and Ryan McKay and Daniel Dennett (2009) also partially endorse a Wakefield-inspired account of what makes delusions 'doxastic dysfunctions'. The harmfulness thesis scarcely needs to be argued for. As discussed above, in most people with delusions good functioning is compromised, but we need to consider whether it is the delusion causing the harm as opposed to the delusion being co-occurrent with harmful experiences. The malfunctioning thesis depends on the plausibility of an aetiological story involving a deficit or a dysfunction: as we saw, for Maher-style theorists the problem is likely to be the anomaly of the experience; for Corlett-style theorists the problem lies with prediction-error signals affecting attention and automated learning; and for two-factor theory the problem is either a reasoning deficit or a reasoning bias.

By adding the harmfulness condition to the malfunctioning condition, the combined approach to the pathological nature of delusions surpasses the naturalist approach in that it provides a way to rule out the claim that self-deceiving beliefs and everyday confabulations are pathological: so-called 'normal' beliefs that are the outcome of deviant aetiological processes do not count as pathological unless they are also harmful. However, the necessity of identifying a deficit or a dysfunction in the process contributing to the formation or the maintenance of the belief makes this account of the pathological nature of beliefs ill-suited to guide judgements concerning the appropriateness of medical attention. Due to the implication that medical attention is appropriate only for those beliefs that are the outcome of a deficit or a dysfunction as opposed to all harmful beliefs, decisions about the appropriateness of medical attention depend on our capacity to ascertain the involvement of a deficit or a dysfunction, which is often a challenge. Based on the output (e.g., an irrational

belief), it is difficult to determine whether it was a dysfunction in the process of belief fixation or belief maintenance or some other factors (e.g., a performance error or a motivational factor) that was responsible for the belief being adopted or maintained.

Delusions are only pretend beliefs.

Finally, one could argue that delusions are pathological because they present themselves as something that they are not—they are just *pretend beliefs*. According to this view, popular with researchers who view delusions as non-doxastic states, delusion reports *sound like* belief reports and people reporting a delusion *seem to* be stating something they believe, but that is not the case. Anti-doxastic arguments converge on the fact that delusions do not share some of the core features that we would expect beliefs to have, such as action guidance and responsiveness to evidence, and are irrational to a higher degree than or in a qualitatively different way from everyday irrational beliefs (for a discussion of aspects of this view, see Currie and Jureidini 2001 and Frankish 2009).

One powerful reason for anti-doxasticism about delusions is that delusions allegedly fail to play the folk-psychological or the functional role that we would expect beliefs to play. As previously discussed, the content of some delusions can be so puzzling, and the delusion be so badly connected with the person's other beliefs and so poorly supported by evidence as to defy the folk-psychological expectations on which we base our everyday practices of interpretation and prediction of behaviour. On some views (Campbell 2001; Murphy 2012; Schwitzgebel 2011), this would make it very arduous or even impossible to make sense of people's behaviour by ascribing *beliefs* to them.³ Such reasons for anti-doxasticism do not seem to apply equally well to mundane delusions such as delusions of jealousy, grandeur and persecution, or motivated delusions where the delusional state serves as a defence mechanism.

On one view, what is disturbing is that people reporting delusions take themselves to *believe* the content of their delusions, whereas they merely *imagine* it or *accept* it. Thus, they make a mistake by identifying their delusions as beliefs. Even if it were true that people with delusions are guilty of such a metacognitive error, this would not give an answer to what

³ Further elaborations of the idea are that people with delusions inhabit a fictional, non-actual reality and no longer share some fundamental assumptions and practices with the people around her can be found in Stephens and Graham (2004 and 2006); Sass (1994); Gallagher (2009); Rhodes and Gipps (2008).

makes them ‘disordered’ that could explain why their delusions are the appropriate object of medical intervention. That is because, the same brand of anti-doxasticism can be applied to other phenomena such as superstitions, conspiracy theories, religious convictions, self-deceptions, biases and prejudices. Those non-delusional pretend beliefs are common in the non-clinical population and are not symptomatic of any mental disorder. Even in those cases, people would mistakenly attribute beliefs to themselves. This suggests that being a pretend belief caused by a metacognitive error is not sufficient for being pathological. For instance, Anna Ichino (2020), who endorses a non-doxastic account of confabulations and delusions, argues that superstitions appear to be beliefs but they are often imaginings, and that in some contexts we fail to acknowledge their non-doxastic nature, just as we do with confabulations and delusions. In Ichino’s view, there is a meta-cognitive mistake at work where an imagining is interpreted as a belief. People with superstitions or delusions misinterpret themselves as committing to the truth of the superstitions or the delusions, whereas the content of the states they report is something that they just imagined to be true. If both garden-variety superstitions and clinical delusions are imaginings disguised as beliefs (see also Ichino 2017), that means that being a pretend belief is not sufficient for attracting medical attention.

To conclude, we saw that there are several accounts of the pathological nature of delusions and carefully reviewing them helps us understand how complex and heterogeneous the phenomenon of delusions really is. However, going back to Wakefield’s initial dichotomy, the reviewed proposals fail to provide a clear demarcation between distressing or unusual beliefs that constitute *medical problems*, and distressing and unusual beliefs that are mere *problems in living*.

V. Medical problems as problems in living

In our society medicine promotes and restores health but also addresses those problems in living (I would call them “obstacles to successful agency”) for which we feel—as individuals or as a society—that medical expertise and medical intervention can provide solutions or relief. I suggested that we do not need the notion of disorder to tell us what medicine is for because it is not (just) the nature of the problems we encounter which determines how we respond to those problems. Plunging into the uncertainty of not having a well-defined demarcation criterion for which problems are medical problems may be unsettling: it would be comforting to arrive at a notion of disorder that makes sense of the idea that all doctors

do is to prevent and treat disorders. But there is no indication from the literature that such a notion of disorder is forthcoming.

On the bright side, we would make progress with a number of debates if we were to accept the idea that doctors do not deal with disorders alone. Consider this: in mental health activism, there is a very lively and divisive debate about the extent to which medicalising distress is appropriate. Many people who experience distress reject diagnostic labels because of their stigmatising implications and their contested validity, and feel that psychiatry is illegitimately extending its reach by making up new disorders and labelling as pathological behaviours that were previously regarded as normal (Watson 2019; see also Huda 2019 for a different perspective). If we were to drop the ‘disorder’ talk and acknowledge that receiving medical treatment does not imply that our behaviour is abnormal or pathological, then the problem of the medicalisation of distress would likely evaporate. Some problems in living can be improved by medical intervention, other problems cannot. If medication makes my grief more bearable, this does not mean that my grief is abnormal or that I am disordered—grieving may be the most natural way to respond to my life circumstances—but that my *problem in living* has a medical solution, or at least that medical intervention can alleviate some of the negative effects of my problem in living.

One might wonder whether this way of looking at the problem is misleading: isn’t the notion of disorder worth defining in its own right, independent of the role ‘disorder’ has historically played in demarcating medical practice? More needs to be said about this, but the importance of the notion of disorder seems to be grounded in our intention to understand and demarcate the role of medicine. As Cooper (2020) says, ‘disorder’ is a human-kind term, and like all human-kind terms it is subject to shifts that are determined by our evolving interests and sensibilities. Recognising that the notion of disorder is not central to demarcating medical practice prompts some further questions about the need for a notion of disorder. It is liberating to realise that the difficulties in arriving at a coherent and useful notion of disorder can be explored without undermining the role of medicine in our lives.

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