The Conceptual Engineering of Mental Illness

Should we change the mental illness concept?

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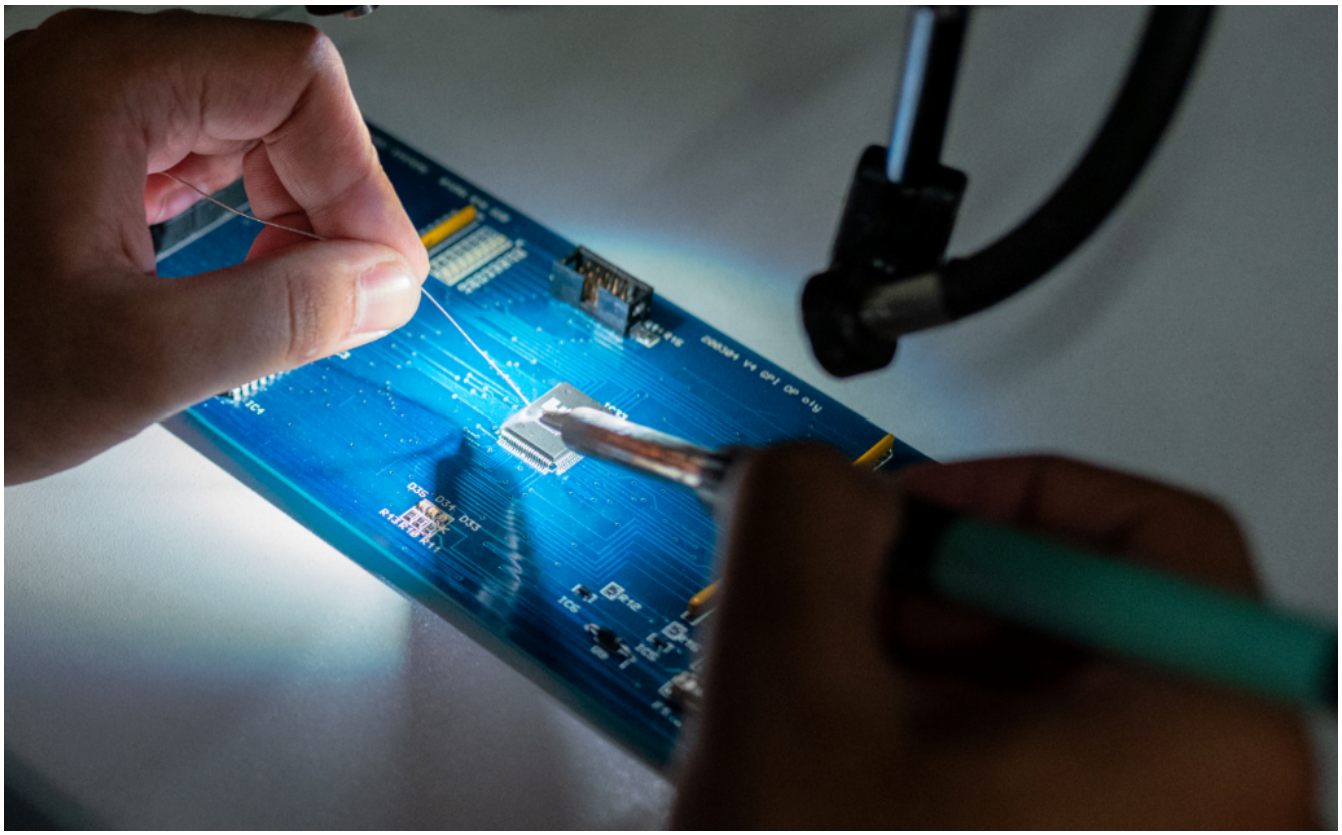

How could the concept of mental illness be engineered? Should it be abolished, ameliorated, or reformed in some way? Can the existing concept be vindicated? This is preliminary exploration to scout the territory and identify questions for further research in the conceptual engineering of mental illness. This project is not simply an attempt to characterize the current semantic content of mental illness. **The issue is not what we happen to mean, but rather what we *should* mean**, given the

concept's immense roles in our social, political, and scientific practices. Inquiry into mental illness must involve conceptual ethics, not just conceptual analysis.

Therefore, this essay proceeds in **three steps: conceptual analysis, conceptual ethics, and conceptual engineering**. These steps roughly map onto Thomasson's pragmatic method for normative conceptual work: (1) reverse engineering the concept to identify its current content and function, (2) identifying the function the concept *should* fulfill, and (3) actually engineering the concept to better serve this function.[2] Part 1 contains conceptual analysis of mental illness, addressing descriptive issues about the concept's definition, content, current function, and conceptual history. Part 2 handles normative questions in conceptual ethics, assessing what function mental illness *should* have and critiquing the existing concept from both epistemic and practical perspectives. Finally, part 3 engages in conceptual engineering, constructing and evaluating a series of ameliorative options.

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Mental illness will be underlined when specifically referring
to the concept, will be in scare quotes when referring to the
lexical item "mental illness," and will be left alone when
referring to the colloquial meaning or phenomena of mental
illness.
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1. Conceptual Analysis

1.1 What is mental illness?

For the purposes of this essay, "mental illness," "psychological/psychiatric disorder," and "mental disorder," will all be considered labels for the same concept mental illness. These terms vary in connotation but have similar intensions and extensions. Additionally, mental illness is a *type concept*: it specifies a category that includes many other *token concepts*, like bipolar disorder and autism. I will abstract away from the token concepts here and concentrate on the broader type concept.[3]

This paper focuses on **mental illness as defined by the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**: a behavioral

or psychological pattern in an individual that results in clinically significant distress or disability and reflects an underlying dysfunction.[4] This is a theoretical concept rather than a folk concept,[5] although the theoretical mental illness concept defined in the DSM-5 heavily influences the commonly used folk concept. The DSM-5 also lists several caveats, including that the behavior must not be simply social deviance or an expectable response to events. Mental illness should also have clinical utility, helping clinicians diagnose and treat patients. Essential to this definition is that mental illness is a medical concept, one intended to facilitate treatment in a clinical setting.

This definition prompts several questions. **What is dysfunction?** Is it deviation from norms, a divergence from evolutionary role, or maybe a harmful difference in neurobiology? The DSM-5 specifies that dysfunction can be psychological, biological, or developmental. But each of these options taken individually suggests different contents. If the dysfunction *must* be demonstrably biological or developmental, then most existing disorders would be excluded because researchers have not identified their neurobiological basis.[6] The definition states that mental illnesses must reflect an underlying dysfunction, but the DSM-5 does not state the etiology of any listed disorder. How can it then establish that underlying dysfunctions cause the harmful psychological or behavioral patterns? This reflects an inconsistency between the approach of the DSM-5, which does not identify underlying dysfunctions, and the definition of mental illness, which requires an underlying dysfunction.

Further, **how much distress or dysfunction is enough to qualify a pattern as a mental illness?** It is plausible that a personality trait like openness to experience could lead to significant distress and impairment, as it is strongly associated with harmful risk-taking behaviors.[7] The DSM-5 does not clarify these issues. Perhaps a mental illness must be harmful on balance, or must cause 'net distress,' without significant benefits that offset the harms. The effects of personality traits depend on the context, and arguably no trait is on-balance harmful. For example, openness has substantial benefits including higher creativity.[8] Personality traits may also lack clinical utility because they cannot be treated effectively and are difficult to diagnose precisely. Clearly, normative and practical concerns are at play here, not just descriptive and theoretical concerns.

The DSM-5 may be intentionally broad to include many types of dysfunction and distress. Vagueness is not necessarily a problem. After all, the DSM-5 clarifies that mental illness is more of a ***dimensional* concept** than a categorical concept: there is a

continuous spectrum between pathologies and non-pathologies rather than a rigid distinction.[9]

Further, **mental illness is a thick concept**: it has both descriptive and normative features. It describes a set of behaviors, psychological conditions, and neurobiological states. But it also contains a normative judgement: these conditions are harmful, non-valuable, or negative, causing distress and dysfunction. A **value-neutral account of dysfunction is unachievable**, as it requires some normative reasoning to explain why a certain kind of function is more positive or better than others. Some token mental illness concepts may be thicker than others, but all involve evaluative components.[10] Mental illness combines both *fact* and *value*, although it may be difficult or impossible to disentangle fact from value.[11]

Conclusively, this conceptual analysis has shown that mental illness is a type, thick, and dimensional concept. The next section will address the function of the concept in our existing conceptual scheme.

1.2 System function

Thomasson defines system function as the capacity a concept serves in the system it is embedded within.[12] What role does mental illness play in our current system? The DSM-5 specifies that its definition was developed for clinical, public health, and research purposes.[13] Thus, one *aspiration* of the concept is to improve health and scientific understanding. The concept may serve this role to some extent. However, it also has other current functions.

For instance, mental illness has **substantial economic, political, legal, and scientific functions**. Over forty thousand psychiatrists in the US rely on the concept to some extent.[14] The global psychiatric market is valued at over $197 billion,[15] while the global market for psychiatric drugs is worth over $88 billion.[16] The DSM itself originated to provide a way for insurance and law to evaluate psychological damages.[17] Furthermore, mental illness is essential to legal concepts like the insanity and diminished capacity defenses, disability evaluations under the ADA,[18] civil competencies, and personal injury lawsuits.[19] The mental illness concept is also indispensable to certain structures of power. Psychiatric power is remarkable in that it seems to even transcend political sovereignty – "madness is, in essence, the ultimate exclusion."[20] For example, when King George III was diagnosed as insane, he was

removed from his authority and placed in isolation.[21] The 25th Amendment also enshrines a provision that could theoretically remove a president diagnosed with a mental illness.[22] Finally, mental illness guides research efforts in psychiatry, sociology, and other scientific fields.

1.3 Does conceptual history matter?

Some of the most compelling critiques of psychiatric concepts have been historical.[23] These genealogies often trace mental illness to defective, objectionable, or harmful origins. However, **does the history of a concept matter in evaluating its present form?** Some might worry that conceptual history is misguided, commits the genetic fallacy, or merely addresses descriptive issues in history without a normative critique of the concept. After all, concepts in chemistry can be traced to alchemy, but this conceptual history alone is not a meaningful critique of these concepts.

Plunkett (2016) argues that **conceptual history can provide descriptive information to evaluate which concepts improve the success of inquiry**.[24] If a concept emerged due to irrational, problematic, or contingent historical processes that are not responsive to our aims, this gives us a prima facie reason to worry about the concept—especially if our justification for using the concept relies on its history. Additionally, the past performance of a concept can indicate its value as a representational tool. If concepts have been unjust or unsuccessful in the past, this informs their likelihood to succeed in the present.

Conceptual history is especially important for thick concepts like mental illness, because it allows us to gain distance from the concept and see how ideology or normativity have merged into descriptive concepts. History can also reveal hidden features of a concept, show that the ostensible role of a concept isn't in line with its actual function, and identify alternate concepts which can serve similar functions. Therefore, **conceptual history does matter, especially for thick concepts with complex social histories like mental illness**. Delving into this conceptual history can be essential to conceptual analysis, providing key descriptive information.

2. Conceptual Ethics

What *ought* to be the function of mental illness? It is difficult to create a complete definition of its ideal function. However, the concept should do at least two things.

First, it should fulfill an epistemic role: describing and providing knowledge about phenomenon that corresponds to mental illness. The concept should be coherent, fruitful, accurate, predictive, and it should be essential to good explanations of phenomena that need explaining.[25] **Second, it should fulfill a normative role:** upholding our practical and ethical aims, including promoting well-being, improving public health, and fostering a just society. The epistemic and normative conceptual goals are analogous to the DSM-5's aims: increasing scientific understanding and public health. At minimum, mental illness should live up to these aims. Furthermore, the concept should be modified or replaced if alternative concepts can better fulfill these functions. This section addresses epistemic and normative criticisms of mental illness.

Simion (2010) argues that **the epistemic role of concepts should be prioritized**, and concept amelioration should be limited to "revisions that do not result in epistemic loss."[101] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-102>Engineering projects should not leave us with concepts that fail us epistemically. Otherwise we might be left with concepts that are essentially "noble lies," optimized for positive normative effects but failing to represent reality. Of course, often epistemic deficiencies will *lead* to a concept's negative effects. But ultimately some conceptual changes will involve tradeoffs between epistemic and normative benefits, and in these cases there is a strong argument for avoiding epistemic losses.

2.1 Epistemic Critiques

2.1.1 Natural Kind?

Many epistemic critiques revolve around the question of whether mental illness is a natural kind. Broadly put, a natural kind is a grouping that reflects the structure of the natural world rather than just human interests or actions, like the chemical elements.[26] There are several competing notions of what constitutes a natural kind. For simplicity, I will use Dupré's account, in which a natural kind is not a set that shares a specific essential property, but a dense cluster of properties in the natural world.[27] **Whether mental illness is a natural kind is a critical issue in determining the epistemic validity of the concept.**

Cooper argues that at least some mental illnesses are natural kinds in the same sense as weeds.[28] Classifying a plant as a weed depends on judging the weed as normatively dis-

valuable for one's purposes (e.g. gardening). But the plants themselves are natural kinds, as they are empirically classified into species based on objective natural properties. **Like the weed concept, mental illness depends on a normative judgement of a natural kind.** However, the behavioral and neurobiological conditions that correspond to a mental illness can be grouped based on natural properties.

In contrast to Cooper, **Hacking argues that mental illness is an interactive human kind**.[112] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-113>
Describing a mental illness results in social processes that alter the very properties under study. The concept changes when it is described, and thus is *interactive* and not indifferent to its description. Cooper responds that mental illnesses can still be natural kinds even if they are affected by social processes. After all, classifying a bacteria species often leads to treatment efforts that change the bacteria, but this does not imply the bacteria is not a natural kind. Social processes like changing diagnoses of autism may lead to changes in the symptoms of autism, but this does not change that autism reflects an underlying natural condition with biological causes.

While Cooper's arguments are valid, she only shows that mental illness as a descriptive phenomenon may be a natural kind. **But mental illness is a thick concept: a normative judgement on descriptive phenomena.** Perhaps the properties associated with mental illness are grouped closely enough to call this collection of phenomena a natural kind; this is an empirical question that has not yet been demonstrated. But the key point is that these collections of phenomena alone do not constitute a mental illness concept. The normative aspects of mental illness are inevitably social creations, not features of the natural world. Even if certain neurobiological, behavioral, or psychological differences are natural kinds, the mental illness concept remains a social kind.

However, **even if mental illness is not a natural kind, it may be a practical kind** – a grouping that is useful enough to support effective induction and ground explanations and predictions.[29] For instance, results from taxometric studies, neurobiology, and experimental psychology **seem to show that individuals with major depression form a distinct group**.[30] If this holds for mental illness in general, it may vindicate the concept. However, critics of this approach argue that statistical clusters of symptoms may simply reflect folk descriptions of distress or common responses and should not be called "illnesses."[31] Clearly, any resolution to this debate must involve deep empirical and philosophical work.

2.1.2 Scientific Problems

Psychiatrists routinely argue that there are neurobiological dysfunctions like 'chemical imbalances' underlying mental illnesses. However, psychiatry has failed to demonstrate that these biological differences exist and are tied to behavioral differences. The largest and most recent umbrella review[32] of biomarkers for mental disorders found that "**no convincing evidence supported the existence of a trans-diagnostic biomarker.**"[33] Although the DSM-5's biomedical mental illness concept implies an underlying neurobiological dysfunction, **175 years of research has failed to show a neurobiological basis for any mental illness.**[34] Neurobiology is not used in psychiatric diagnosis, and there are no validated clinical tests for mental disorders.[35] Davidson notes psychiatric research is characterized by an "obsession with brain anatomy coupled with the constant admission of its theoretical and clinical uselessness."[36] Despite ongoing promises, psychiatry has not identified clear etiologies, biological aberrations, or clinical tests for mental illnesses. Thus, the biomedical concept fails to satisfy its own desiderata.

Adding to these deficiencies, **mental illness diagnoses are notoriously unreliable.** Most DSM categories lack construct validity and have little predictive power.[37] A cascade of studies in the 1970s demonstrated that psychiatrists only agreed upon diagnoses about 50% of the time.[38] A more recent quantitative review of 311 taxometric findings concluded that **there was almost no replicated evidence for discrete psychiatric categories.**[39] This unreliability can be traced to serious conceptual problems. Mental illnesses are often defined tautologically or incoherently. For instance, psychiatrists may claim that the cause of a person's mood swings is bipolar disorder, and the evidence the person has bipolar is her mood swings. This response can only escape tautology if some clear external cause can be identified, like a specific neural aberration—but no mental illness has firmly identified etiology. Many diagnoses are also extremely vague or ambiguous. For instance, what constitutes "excessive anxiety"? The general concept of mental illness is also vague, as addressed in section 1.1. While some categories may be useful, the current approach to mental illness has not resulted in accurate categorization.

Psychiatry also has a bad track record of modifying mental illness when it fails to describe the world accurately. Despite explanatory failures, a lack of pathological neuroanatomy, and ethical harms, psychiatry retained since-debunked mental illnesses like 'sexual perversions,' homosexuality, and female hysteria.[40] These constructs were

only scrapped after persistent social pressures from *outside* psychiatry.[41] This **conceptual history riddled with epistemic failures** casts some doubt on the validity of the existing understanding of mental illness. While the problematic disorders have been removed, the overarching mental illness concept that resulted in these failures has hardly changed.

Finally, mental illness as defined in the DSM-5 assumes that mental illnesses are relatively universal if not culturally invariant. This results in prioritizing Western understandings of mental health and illness and "homogenizing the way the world goes mad."[42] However, **mental illnesses vary dramatically across cultures,** and some clusters of symptoms exist only in specific times or places.[43] In Hong Kong, symptoms of anorexia did not appear until Western psychiatry exported the concept; in Zanzibar, schizophrenia in the American form replaced existing symptoms; in Japan, the Western concept of depression was marketed by multinational pharmaceutical corporations and quickly replaced the indigenous disorder called *yuutsu*.[44] Ethan Watters' detailed studies of these phenomena show that "culturally designated pathological states are often the flipside of states a culture values."[45] Treating certain behavioral patterns as diseases inevitably reflects the norms of specific societies, and mental illness primarily reflects Anglo-American values. Exporting this culturally specific concept may be a form of psychiatric colonialism that results in both epistemic inaccuracies and negative impacts.

2.2 Normative Critiques

2.2.1 Treatment Failures

The epistemic defects of mental illness may impair the success of treatments based on this concept. In line with this prediction, **psychiatry has serious practical failures in helping those it is intends to treat.** The life expectancy for patients with mental illnesses has declined since the 1950s.[46] Suicide rates for patients with schizophrenia have increased by over 10 times.[47] Psychiatric treatment failed to improve outcomes for schizophrenic patients in 37 countries, and 66% of subjects found that antipsychotic medications completely lacked effectiveness.[48] Analysis of data from 1990 to 2015 in high-income countries found that "despite substantial increases in the provision of treatment" the prevalence of mood & anxiety disorders and their symptoms has not decreased.[49] Another large cross-national study found that on five out of six

dimensions, mentally ill patients in developed countries had significantly *worse* outcomes then those in developing countries.[50] Developing countries have *less* adoption of the mental illness concept addressed here, fewer psychiatrists, and less access to pharmaceutical treatments. The fact that patients have *better* outcomes in these countries is not a good sign for the mental illness concept or casts doubt on psychiatry in general.

The **development of psychiatric categories also faces serious methodological problems.** Almost 50% of research on drugs is ghostwritten by non-experts or otherwise abnormally written.[104] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-105> In many psychiatry journals, more than 90% of authors receive research funding from drug companies.[105] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-106> Furthermore, 70% of the DSM-5 task force members had direct ties to the pharmaceutical industry.[106] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-107> It is also hard to argue that a 480% increase in the number of mental disorders over fifty years is merely the result of rigorous and unbiased scientific discovery.[107] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-108> Given the rapid growth of mental illness diagnosis and treatment "we may soon reach a point when it is statistically deviant not to be taking one of these medications," and strange to *not* be diagnosed with a mental illness.[108] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-109>

Can we trust mental illness categories to adequately describe the world when their development is so influenced by these factors?

However, some treatments for mental illnesses may be effective. For instance, one review of 94 meta-analyses compared psychiatric drugs to medical drugs and found that psychiatric medications were not generally less effective.[51] For instance, lithium was associated with reduction in bipolar relapse rates from 61% to 40%. Ultimately, **whether or not psychiatric treatments are effective is a difficult empirical question that cannot be resolved here.** However, psychiatry's effectiveness is certainly not spectacular, and its remarkable failures cast doubt on the value of psychiatric concepts.

2.2.2 Social Costs: Oppression, Stigmatization, Marginalization

Mental illness may also have serious ethical harms that justify revising or rejecting the concept. For example, people judged as mentally ill can be involuntarily committed and

are often deprived of freedom in psychiatric wards.[52] The concept is also often used to deny employment, legal rights, equal treatment, and epistemic status to those who are seen as mentally ill. In this way, **classifying people as mentally ill may function as a mechanism of social control**, "a cunning way of excluding certain people or certain patterns of behavior."[53] Perhaps the concept gives pseudo-medical authority to practices of ostracism and moral condemnation.[54] Some argue that the concept should be changed or abolished to prevent these normative harms.

Some argue madness is fundamentally a failure to coordinate one's behavior correctly with society, or a failure to conform to social and economic norms. Under this view, the DSM is a device to evaluate and improve the administration of human capital, and to predict "risks connected to the future exploitation of such capital."[109] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-110>
Psychiatry often "provides concepts and languages for marketers to use," and the mental illness concept is essential for pharmaceutical industry, which often "markets diseases in the expectation that sales of the pills will follow."[110] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-111>Major depression linked a wide range of common symptoms to a purported natural kind, which was an "enormously profitable gift to the pharmaceutical industry," making SSRIs the bestselling drug category in the US, with almost 10% of the population using them.[111] < https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-112>If it is the case that mental illness functions to justify arbitrary discrimination against infringements of socio-economic norms, then it may not be a concept worth keeping.

Mental illness does often serve to legitimate the rejection, dismissal, or marginalization of 'mentally ill' people. This often employs weaponized uses of the mental illness concept, like "crazy," "insane," "loony," and at least 250 other stigmatizing labels.[55] Bolinger argues that these terms are slurs, as they insult both the target based on their group membership, reinforcing "the assumption that people with mental illnesses ought to be generally dismissed as epistemic agents" and representing mentally ill people as deserving bad treatment.[56]

Stigmatization is a major cost of the concept of mental illness. Internalized stigma explained 74% of the variance in suicide risk for individuals with schizophrenia,[57] and correlates with higher symptom severity.[58] Even after multivariate analysis, internalized stigma is associated with more suicidal ideation, suicidal risk, number of suicide attempts, and depression.[59] A longitudinal research design also found that self-

stigma was significantly associated with suicidal ideation.[60] **Education on mental illness does not improve outcomes – it tends to worsen them**. Psychoeducational programs are associated with increased suicidality, and awareness of illness is related to suicide risk.[62] Adolescents who self-label as mentally ill had higher ratings of self-stigma and depression.[61] < https://www.jeremyhadfield.com/wp-admin/post-new.php#post-789-footnote-62> Another study found that developing insight into having a mental illness increased depression.[63] Mental illness serves to promote stigmatizing views, and therefore this concept may be more harmful than helpful.

Leslie argues that **certain linguistic constructions like generic concepts can encourage essentializing social kinds**, leading to both cognitive mistakes and harmful stereotyping.[64] In line with this argument, extensive surveys and experiments have shown that essentialist thinking about mental illness is linked to stigma. Both laypeople and clinicians tend to believe that mental disorders are discrete, biologically based, and have inherent causes and properties, showing that essentialism dominates psychiatry and folk thinking.[65] People who endorse the biomedical mental illness concept distance themselves more from those seen as mentally ill, perceive them as more dangerous, have lower expectations of their recovery, and show more punitive behavior.[66]

Finally, a key idea of Hacking's work is that "people spontaneously come to fit their categories," and categorization creates new kinds of people.[67] It is not just that 'what is measured can be managed,' but **what is measured can be *created*.** For example, Hacking shows that the classification of multiple personality disorder in 1875 created a rush of people who exhibited the syndrome.[68] **Diagnostic categories also create corresponding identities**. People tend to 'have' physical illnesses but 'be' mental illnesses. For example, diagnosed individuals have extreme difficultly de-labeling from psychiatric disorders like "bipolar," "anorexic," or "OCD."[69] As one patient said, "we start to define ourselves in a way that's hard to break because we really believe that's who we are."[70] This may lead persons to adopt a 'sick role' that hinders their recovery and flourishing.

Diagnosed individuals tend to understand their own behavior in terms of dysfunction, and often identify as disordered their entire lives. **People adapt to the concepts used to represent them.** For instance, oppositional defiant disorder stigmatizes defiance as an illness, resulting in discipline practices that disproportionately harm young Black men – and if ODD is an interactive kind, those diagnosed with the

disorder may "respond to their classification by exhibiting closer approximations to it."[71] Clearly, mental illness can create group identities or new kinds of people. **If this identity-creation has negative results, this is a reason to reject or modify mental illness.**

3. Conceptual Engineering

3.1 Why engineer mental illness?

Mental illness is uniquely amenable to conceptual engineering. First, it is **easier to engineer than many other concepts.** Unlike concepts like woman, the meaning of mental illness is heavily influenced by a central body (the DSM-5), and thus its intension can be more easily changed by convincing the central body to revise its definition. Mental illness is **no stranger to conceptual engineering.** Previous efforts have successfully changed the concept, e.g. modifying the intension to exclude social deviances and removing homosexuality from the extension. In the 1950s the Renard School of psychiatry helped restructure mental illness from a psychoanalytic to a biomedical concept.[72] Of course, we should try to improve even the most difficult-to-change concepts if we have good normative reasons to do so. But mental illness is a low-hanging fruit that can serve as a proving ground for conceptual engineering efforts.

Additionally, as argued in section 2.1.1, mental illness is **more of a human kind than a natural kind**. Natural kinds can retain meaning despite changes in use. For instance, the extension and use of "number" have changed to include imaginary numbers and more, but the meaning of "number" itself remains the same.[73] If it is true that natural kinds have non-plastic meanings, they may be difficult to re-engineer. Human kinds are more tractable for engineering projects because their meaning is largely defined by their use in social contexts. As Simion argues, "when it comes to concepts representing social rather than natural kinds, by conceptually engineering, we would be, in effect, changing the world."[74] Insofar as mental illness is a social/human kind, and language is constitutive of social reality, **changing the concept may change the world itself.** But this is a double-edged sword: changing the concept may also require changing the structures of the social world (reality engineering).[75]

This project also has importance beyond mental illness. As Capellen points out, a general theory of conceptual engineering can guide specific projects, and these practical

projects can inform the theory.[76] **Exploring or implementing changes can improve our understanding of how conceptual engineering works in practice.** It can also uncover issues and approaches that apply to other conceptual engineering initiatives. These features of mental illness make it a vital area for conceptual engineering.

Proposals to modify mental illness will generally fall into three categories that correspond to Cappelen's varieties of ameliorative strategies.[77] First, abandonment proposals argue the concept should be eliminated entirely. Second, meaning change proposals argue for keeping the lexical item "mental illness" while its meaning is revised. Third, some proposals argue that both the lexical item and the meaning of mental illness should be revised. I do not exhaustively survey possible proposals but construct examples of each type.

All conceptual engineering proposals, especially the third type, will tangle with **difficult issues in topic continuity**. If mental illness is altered, how do we know if we are still addressing the same idea and have not simply changed the subject? Conceptual engineers can use several replies to the topic continuity objection that are addressed elsewhere.[78] The proposals below are united in that they address (a) the same existing mental illness concept, and (b) attempt to fulfill the *function* of this concept in better ways. More radical proposals not discussed here may argue that inquiry into mental illness should be abandoned entirely, its function completely discarded.

3.1 Abandonment

3.1.1 Complete abolition

Advocates of abolition might argue that the concept's epistemic deficits and normative harms are so substantial that **we would be better off without it.** These approaches may or may not provide an alternative to fulfill the conceptual vacuum. However, these proposals will face serious challenges. **Without mental illness, how can the functions of this concept be pursued?** How can psychiatric inquiry proceed? Will those with neurological or mental disorders be left without hope of treatment? These challenges are daunting enough that very few propose the abolition of mental illness.

However, in *Abolishing the Concept of Mental Illness*, Richard Hallam takes these challenges on. He argues that "psychiatry does not have to base itself on a presumption of pathology," and that "if the concept of mental illness were to be abolished, our response to woes would have to be thought through anew."[79] Mental and behavioral differences should be referred to in "a more neutral way" that allows individuals to construct "non-illness identities."[80] These differences can still be studied and treated (if the individual chooses). However, **they should not be pathologized**. Abolition may therefore avoid many of the harms of stigmatization and negative identity-creation, while allowing scientists to study and develop treatments for neural differences in a less biased way.

3.1.2 Abolish overarching concept, keep (some) sub-concepts

Others argue that individual diagnostic categories are worth keeping, but **we do not need a type concept mental illness and it should be abolished**. After all, medicine does not need to define a unitary and generalized disease concept to effectively study and treat specific physical ailments.[81] Can a single representation of mental illness really be useful in the immense variety of contexts it is applied to? As Jaspers writes, "we do not need the concept of 'illness in general' at all and we now know that no such general and uniform concept exists."[82] As such, psychiatry should jettison the abstract, all-encompassing definition of mental illness and the finite lists of illnesses grouped under this concept. Individual token concepts, like autism, will only be kept if they are valuable.

Some type concepts under the overarching mental illness concept might be particularly problematic. For example, Charland argues that cluster-B personality disorders are filled with moral judgements masked by clinical descriptive language.[102] <https://www.jeremyhadfield.com/wp-admin/post.php?post=789&action=edit#post-789-footnote-103>

For example, antisocial and narcissistic personality disorders are defined by clearly normative concepts like dishonesty and recklessness. They require essentially *moral* treatment that changes the individual's moral character. Perhaps concepts like narcissistic personality disorder should be abolished entirely. Instead of treating these conditions like biomedical concepts they should simply be described with moral concepts. However, clusters A and C are *less* normative, as they are defined by descriptive empirical conditions. For example, schizoid personality disorder is specified by anhedonia, lack of close friends, and solitary activities — qualities that are in principle empirically observable. These concepts may be kept. This example shows how

it could be possible to eliminate or alter *token* concepts under the overarching mental illness concept, without altering the type concept itself.

Proponents list several benefits for this kind of conceptual move. First, abolishing the overarching concept may have epistemic benefits, allowing researchers to accurately represent the natural world and make progress in understanding specific mental conditions. While individual mental disorders like bipolar and autism may be natural kinds, the mental illness concept itself is not a natural kind, as it is a collection of distinct conditions with no defining natural properties in common.[83] Grouping phenomena into mental illness might be useful if this category allowed us to see high-level patterns, but this is not the case; **there are no general patterns or features that unite all these mental conditions.** Scientific advances in psychiatry, neurobiology, and genetics indicate that there are "inherently fuzzy boundaries between disorder and non-disorder."[84] Instead, this overarching concept may encourage generalizations and bad inferences about all of its sub-concepts.

Second, as section 2.2 shows, **grouping people under mental illness also allows for oppression and stigmatization**. Removing the overarching concept could help prevent the generalization that sustains these harmful social effects.

3.2 Keep lexical item, change meaning

3.2.1 Haslangerian Amelioration

Haslanger argues that we should change the meaning of certain concepts to achieve ethical aims like social justice. The key question is "whether tracking, communicating, and coordinating around" the concept is a good idea.[85] Given the concept's role in oppression, perhaps we could construct **an ameliorative new definition of mental illness in a Haslangerian fashion**:

> A group G is "mentally disordered" or "mentally ill" (in context C) iff$_{df}$ Gs members exhibit similar behaviors, thoughts, or psychologies (in C); are subject to negative treatments including but not limited to subordinate status, reduced agency, and ignored speech and thought; and the members are "marked" by the dominant ideology (in C) as a target for these negative treatments by neurobiological or behavioral features presumed to be evidence of diminished or flawed mental capacities.

Would this definition be emancipatory? At the very least, this definition reveals "features of our meanings that we were mostly unaware of,"[86] as it exposes an ideology of marginalizing the mentally ill. Perhaps this new concept "cuts at the social joints" more effectively by explaining how a group is oppressed based on certain marks.[87] This amelioration might also reduce oppression, as "mentally ill" would no longer imply that someone is less deserving of equal treatment, but rather that they **happen to be marginalized based on a mental feature**. It would also allow the "mentally ill" to organize around the shared condition of being oppressed by by sanism[88] or ableism. What needs changing is not the individual, but the social structures that oppress and fail to accommodate the individual.

This proposal is vulnerable to many of the same criticisms that have been aimed at Haslanger's projects. First, this amelioration may be a **topic change**—we are no longer talking about mental illness. Second, this amelioration is **extremely difficult to achieve.** Why fight two battles: (a) showing how a group is oppressed, and (b) attempting to change the use of words for this group in counter-intuitive ways?[89] Under (a), instead of revising the concept we can improve our understanding of the existing concept, realizing that mental illness functions to oppress and marginalize certain groups. It seems simpler to only attempt (a), and perhaps more effective.

Finally, a critic might respond that mental illness is **not analogous to race and gender,** it because it is actually the case that people deserve different treatment (e.g. less epistemic trust) based on certain mental features. For instance, if a person has severe brain damage, or is currently in schizophrenic psychosis, perhaps we shouldn't give their statements exactly the same weight as those of a normal epistemic agent. However, it seems better to evaluate statements based on their merits rather than the issuing agent. And often mental illness is simply applied to agents whose speech one would like to reject.

3.2.2 Descriptive Reformulation

The **descriptive reformulation project** argues that we should revise all mental illnesses so that they depend entirely on nonmoral concepts and conditions that can be identified empirically.[90] Under this project, mental illness would essentially be used to refer to physical illnesses of the brain and nervous system that lead to dysfunction that can be described in an evaluatively neutral way—e.g. without appealing to social norms or moral standards. Advocates claim this project can both avoid normative judgement and set psychiatry on stronger scientific and epistemic grounds.

For instance, some researchers argue that psychiatry should adopt a 'stratified medicine' approach toward mental illness, aimed at identifying biomarkers or cognitive tests that stratify each mental disorder phenotype "into a finite number of treatment-relevant subgroups."[91] Some major recent projects have attempted to create **strictly biological classifications of mental disorders** which do not map onto existing DSM-5 diagnoses.[92] This project may argue that if a candidate "mental illness" does not correspond to an *identified* neurobiological dysfunction, then it is not a mental illness.

The primary objection to this project is that it is not possible. First, scientific evidence casts doubt on the existence of descriptive properties like biomarkers that can qualify something as a mental illness. Second, there is no way to call something a "mental illness" without using normative concepts of some kind. Even in medicine, **health requires a standard of well-being or functioning that requires normative judgements.** Some proponents may argue that dysfunction can be evaluated descriptively. For example, perhaps we can identify evolutionary dysfunctions that correspond to mental illnesses. But this still involves normatively disvaluing evolutionary dysfunction. Furthermore, many mental illnesses have adaptive benefits,[93] and evolution alone cannot entail that any particular use of a trait is 'more functional.' It seems that any evaluation of dysfunction requires normativity.

However, this project could be salvaged by altering it slightly. Perhaps we should abandon the normative notion of dysfunction as well. Psychiatry should instead develop **value-neutral classifications of behavioral, psychological, and neurobiological conditions**, each associated with treatments that individuals can select if they choose.[94] None of these conditions would be considered dysfunctions or classified into illnesses.

3.3 Change both lexical item and meaning

3.3.1 Replace with Reclaimed Term

Some may argue that abnormal psychologies are not negative, and thus should not be called 'mental illnesses.' As one schizophrenic individual wrote:

> "I consider myself the luckiest of individuals and I am most pleased with this mind... My life is an adventure, not necessarily safe or comfortable, but at least an adventure."[95]

Many 'mentally ill' people agree. Advocates of this revision argue that just as being disabled is not having a "broken or defective body," but simply a minority body, perhaps 'mental illness' is just having a minority brain.[96] This is not a bad-difference, but a mere-difference. For disabled people, it is the "experience of being disabled that is itself constitutive of some of the goods in their lives."[97] In the same way, mental illness can be essential to certain goods—for instance, "Madness might represent another possible way of seeing."[98]

Thus, some advocate a neutral or positive concept for these states. First, the revisionist could keep "mental illness," **changing its meaning so that it has no negative evaluation or connotation**. For example, terms like "queer" and "crip" were reclaimed not by changing who the term applied to, but by changing the "affective, expressive component in the concept."[99] However, this kind of revision is difficult when the term "illness" entails almost inbuilt negative evaluations & connotations. Second, the revisionist could abandon "mental illness," and replace it with a new lexical item with a new meaning. This concept could be (1) a reclaimed term with existing negative connotations, like "mad," "crazy," or "insane," (2) a currently positive or neutral term like "shaman" or "neurodivergent," or even (3) a neologism. Replacing mental illness with a more positive conception may improve our social practices towards psychological difference.

4. Conclusion

Conflicts over the meaning of mental illness are **proxy battles**, the linguistic site of an underlying struggle over the purposes of psychiatry. **The concept has immense**

impact. Falling within the extension of mental illness can enable access to treatment and insurance, legal protection, and entry to support and advocacy groups. It can also lead to involuntary commitment, social stigma, and exclusion. **Given its significance, ensuring that mental illness fulfills our epistemic and ethical aims is critical.** If the concept is defective, it could lead scientific efforts astray; if it has negative ethical effects, revising, replacing, or even abandoning it could help prevent harm.

Most researchers recognize that the concepts and terms of psychiatry can be revised: "as a linguistic sign, **madness becomes available for our critical manipulation**."[1001] What is not clear is how these concepts function currently, what they should mean, and how we can change them. Through the process of conceptual analysis, conceptual ethics, and conceptual engineering, this essay explores these issues. By **introducing the fruitful methodology of conceptual engineering to psychiatry,** philosophers can develop and clarify their descriptions, critiques, and proposals for conceptual improvement.

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Appendix

Foucault, Szasz, problems with madness

Foucault cites the influential French psychiatrist Pinel, who argued that the mad should be treated as *morally* ill and not imprisoned. Insane people should be freed from their shackles, and treated with (a) silence, (b) encouragements to see their own reflection and recognize their madness, and (c) perpetual judgement by their caretakers to encourage more sane behavior. Foucault argues that this "liberation" is really a form of subjugation, meant to inflict the mad person with constant shame. Their punishment is made invisible and used to mold the 'mad' people into "disciplined bodies." Mental illness is diagnosed by conduct but treated biologically.

Footnotes

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