# Vice and the Diagnostic Classification of Mental Disorders: *A Philosophical Case Conference*

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Abstract: This main article for a *Philosophy, Psychiatry, & Psychology* philosophical case conference is intended to raise philosophical, psychiatric, and public policy issues concerning the relationship between concepts of criminality, mental disorder, and the classification of mental disorders. After introducing the basic problem of the confounding of "vice" and mental disorder concepts in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition—Text Revision,* the author summarizes three different cases from the literature that illustrate the problem of the vice–mental disorder relationship. Four general aspects of the conceptual issues are presented to frame the discussion, and general questions in a range of domains are posed for commentators.

Keywords: diagnosis, classification, criminality, DSM, mental disorders, misconduct

For this Philosophical Case Conference in *Philosophy, Psychiatry, & Psychology* (PPP), I present three clinical cases from the literature which introduce a cluster of conceptual problems pertaining to the diagnostic classification of mental disorders. The cases are intended to both be introductory and provocative to later discussion by commentators. As will be seen from the discussions following, the implications for the confounding of what I call "vice" with mental disorders goes beyond the philosophy of psychiatric diagnosis, research, and practice. Indeed, I believe this discussion will lead to substantive philosophical implications about what psychiatry is, about its social-moral role, and how psychiatry relates to the law and the body politic in general. Because these conceptual issues have such multiple implications for our interdisciplinary field, a PPP Philosophical Case Conference seemed an ideal forum for exploring them.

The gist of the issues raised here concern the clinical descriptions and diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) classifications of disorders. Some of these disorder descriptions betray substantial criminal and/or morally wrongful meanings. For other disorder categories, this presentation of moral wrongfulness is largely absent. To start, three different kinds of case summaries are presented,

drawn from three sorts of essays. The case selections are based on the breadth of the diagnostic and conceptual issues involved, but also because the format of their case presentation draws out different sorts of conceptual issues.

After the bald presentation of the case examples, I summarize briefly the conceptual, social, and clinical background of what I call the "vice–mental disorder relationship." I then unpack a series of conceptual issues concerning the vice–mental disorder relationships, referring back to the introductory cases. My focus is exclusively on the DSM for brevity's sake, although similar issues with the ICD classification could be drawn out in commentators' discussions. I provide a modest amount of "interim analysis" of the issues as a framework to extend the discussion for the Philosophical Case Conference participant–commentators. I conclude by raising questions in a range of conceptual domains. I hope that my and the commentators' discussions about these issues will be a positive contribution to the evolving DSM-V and ICD-11 efforts, and contribute to ongoing work on the problems presented.

Perhaps the core issue concerning the cases to follow involves the relationship between criminal behavior (criminality), wrongful conduct, and mental illness and how these relationships appear in official diagnostic manuals—my exemplar here being the DSM-IV-TR (American Psychiatric Association [APA], 2000). For purposes of convenience, I have adopted the use of "vice" as a technical term referring to criminal (illegal) behaviors and attitudes/behaviors that could be considered "wrongful" or "immoral" in the social arena. So using the "vice" term, the central problem raised here is that the meaning of some DSM categories and criteria are confounded by "vice" meanings. What this main article will show is that the DSM-IV-TR confounds the concepts of vice and mental illness through a variety of commissions, omissions, and inconsistencies. These confounds will be shown to have important implications (and offer important opportunities) for the relationship between crime, criminality, wrongful conduct, and mental illness, and their associated professional practices and public policies.

## Cases

### Case 1: "I'm Not Right Up Here" (quoted from the DSM-IV casebook)

Phillip, age 12, was suspended from a small-town Iowa school and referred for psychiatric treatment by his principal. The following note came with him:

> This child has been a continual problem since coming to our school. He does not get along on the playground because he is mean to other children. He disobeys school rules, teases the patrol children, steals from the other children, and defies all authority. Phillip keeps getting into fights with other children on the bus.
>
> He has been suspended from cafeteria privileges several times for fighting, pushing, and shoving. After he misbehaved one day at the cafeteria, the teacher told him to come up to my office to see me. He flatly refused, lay on the floor, and threw a temper tantrum, kicking and screaming.
>
> The truth is not in Phillip. When caught in actual misdeeds, he denies everything, and takes upon himself an air of injured innocence. He believes we are picking on him. His attitude is sullen when he is refused anything. He pouts and when asked why he does these things, he points to his head and says, "Because I'm not right up here."
>
> This boy needs help badly. He does not seem to have friends. His aggressive behavior prevents the children from liking him. Our school psychologist tested Phillip, and the results indicated average intelligence, but his school achievement is only at the third- and low fourth-grade level.

The psychiatrist learned from Phillip's grandmother that he was born when his mother was a senior in high school. Her parents insisted that she keep the baby and help rear him; most of his upbringing has been by his grandparents, however.

Phillip was "3 months premature" and a "blue baby," requiring oxygen for 24 hours. Shortly after his birth, Phillip's mother ran off with a man, married him, and had a second child. The marriage broke up, and she left this child with its father. Phillip has had no contact with his mother since she left him.

Phillip's toilet training was not successful, and he remained a bed-wetter for some years. At age 5, his maternal grandparents adopted him because they were afraid that his mother might some day claim him. He showed anxiety at separation from his grandmother when he began school.

He was then in a serious car accident, in which his grandmother was injured and one person in the other car killed. Phillip did not appear to be injured, but seemed to have some transient memory loss, probably a direct, immediate result of the impact. Subsequently, he had nightmares, fear of the dark, and an exacerbation of his fear of separation from his grandmother.

Phillip's school progress was not good. He repeated third grade and then was in a special class for underachievers. His grandmother recalls that Phillip's teacher complained that he "could never stay in his seat."

A few months before the consultation, Phillip was seen in a mental health clinic and placed on some mild tranquilizers. A 3-month return appointment was arranged, but the school suspended him before that date. (Spitzer et al. 1994, 358–360; [case adapted from Jenkins 1973, 60–64])

The authors go on to describe Phillip's DSM-IV diagnosis as Conduct Disorder, Childhood Onset Type, and describe a provisionally optimistic treatment outcome. The DSM-IV-TR diagnostic criteria for Conduct Disorder are listed in Table 1.

## Case 2: "A Vicious Circle"

The original intent for this article and case by Adshead and Bluglass (2001) is to illustrate transgenerational attachment difficulties as a theoretical explanation for factitious disorder by proxy syndrome. The case discusses a child, "child A," who has been presented as ill by the mother, Miss A. The mother of Miss A and the grandmother of Child A, Mrs. A, is also discussed in the context of the aforementioned transgenerational attachment issues. The DSM-IV-TR Diagnostic Criteria for Factitious Disorder and Factitious Disorder Not Otherwise Specified are listed in Table 2. In this case, the DSM-IV-TR diagnosis would be the latter. Again, extensive quotations are used from the original work.

The case involves Child A, Miss A and Mrs A. Child A is the only child and daughter of Miss A, who is the only child and daughter of Mrs A. Miss A presented Child A to pediatricians as suffering from apneic attacks (breathing difficulties). After multiple investigations, it was suspected that Miss A was inducing the apneic attacks by smothering Child A. Miss A vigorously denied the accusations, and blamed the doctors involved for failing to find a cause for her daughter's breathing difficulties. She later admitted to one episode of smothering.

**Background histories**

*(1) Child A*. At the time of referral to the pediatricians, Child A was 6 months old. She suffered from eczema as well as 'apneic attacks'. Both her mother and grandmother describe her as having a 'piercing cry', and being 'difficult' about feeding. Child A has also been described as suffering from asthma. Child A is now in local authority care after her mother was suspected of smothering a second daughter (18 months younger than Child A) during admission to a residential assessment center.

*(2) Miss A*. As a child, Miss A had a history of food allergies which required repeated medical investigation up to the age of seven. She had repeated changes of home as a child because of her father's occupation, and she went to boarding school. Expelled for theft, she was sent to a residential adolescent unit. During this time, she had individual and family therapy. After leaving school, she worked in an old people's home near her parents, but was unhappy there. She took an overdose, and had some counseling, which she said she 'did not need'. She lived with a boyfriend for a year after leaving home at 18, and then moved into rented accommodation. She met her partner at the age of 19, and their daughter (Child A) was born a year later. When asked if the pregnancy was planned, she answered, 'Yes and No.' Her labor with Child A was very painful, but unexpectedly short. Her mother (Mrs A) was present at the birth. Miss A said that she did not bond with Child A for a 'few weeks', and was unable to breast-feed her. She recalled feeling depressed and irritable, and was prescribed antidepressants by her GP [general practitioner]. Social services were involved after Child A's repeated admissions to hospital with breathing difficulties. Miss A told the interviewer that both her maternal grandparents (i.e. Mrs. A's parents) had nervous breakdowns, and that her maternal grandfather had regular 'relapses'. The interviewer perceived Miss A as having a very close but conflicted relationship with her mother. No information was available about Miss A's father or Miss A's experience of him.

*(3) Mrs A*. Mrs A was the youngest of three girls. Her older sister is only 15 months older than she. She described her parents as strict, but said that she 'idolized' her father. She was referred to a child psychiatrist at the age of 10 when she developed nightmares after her paternal grandfather's death. She attended local schools, but did not do well, and her reading skills are poor. After leaving school, she worked in retail, until she joined the occupation where she met her husband. Miss A was a planned conception, born 18 months after Mrs A's marriage. Before Miss A was born, Mrs A miscarried an early pregnancy. Mrs A's father had a 'nervous breakdown' when she was 14, and Mrs A said that her mother relied on her for support. Mrs A has no psychiatric history, but appears to have fixed and rigid

Table 1. DSM-IV-TR Diagnostic Criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:
   Aggression to people and animals
   (1) often bullies, threatens, or intimidates others
   (2) often initiates physical fights
   (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
   (4) has been physically cruel to people
   (5) has been physically cruel to animals
   (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
   (7) has forced someone into sexual activity
   Destruction of property
   (8) has deliberately engaged in fire setting with the intention of causing serious damage
   (9) has deliberately destroyed others' property (other than by fire setting)
   Deceitfulness or theft
   (10) has broken into someone else's house, building, or car
   (11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
   (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)
   Serious violations of rules
   (13) often stays out at night despite parental prohibitions, beginning before age 13 years
   (14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
   (15) is often truant from school, beginning before age 13 years
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.
   Code based on age at onset:
      *312.81 Conduct Disorder, Childhood-Onset Type:* onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years
      *312.82 Conduct Disorder, Adolescent-Onset Type:* absence of any criteria characteristic of Conduct Disorder prior to age 10 years
      *312.89 Conduct Disorder, Unspecified Onset:* age at onset is not known
   Specify severity:
      *Mild:* few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others
      *Moderate:* number of conduct problems and effect on others intermediate between "mild" and "severe"
      *Severe:* many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others

For individuals over age 18 years, a diagnosis of Conduct Disorder can be given only if the criteria are not also met for Antisocial Personality Disorder. The diagnosis of Antisocial Personality Disorder cannot be given to individuals under age 18 years.
(From APA 2000, 98–99.)

beliefs about health. She suffers from 'brittle asthma'. She described Miss A as a difficult child, 'like her father'. She described Child A as 'a precious thing'.

### Case 3: Jeffrey Dahmer

Case 3 summarizes a detailed neuropsychiatric case study of Jeffrey Dahmer, who was convicted of serial sexual murders in the United States in 1992, generating sensational media attention and public interest. The following case summary abstracts the detailed case summary and analysis provided by Silva, Ferrari, and Leong (2002), to which quotations are referred.

Born in 1960 to chemist Lionel Dahmer and his wife Joyce after a difficult pregnancy involving protracted nausea and vomiting and psychiatric symptoms requiring tranquilizers, infant Dahmer exhibited developmental abnormalities very early on, involving difficulties with eye gaze, emotionless facial expressions, and "a certain motionlessness of his mouth" (p. 2). His rigid, robotic body posture, and clumsiness was first noted in childhood, and by age 6 ". . . he was described by his father as a quiet boy who became increasingly inwardly drawn and who failed to negotiate developmentally appropriate peer relationships as a child and adolescent." (p. 2). Dahmer never developed ordinary social relationships. He would engage in sports and music but would transform them into solitary activities if pragmatically possible, or give them up if not. He had tremendous difficulties engaging in social give-and-take, never developing any substantive friendships. In childhood, after discovering skeletons of rodents underneath the family home, Dahmer became preoccupied with them and would "pick a few of them up, then let them fall with a brittle crackling sound that seemed to fascinate him." (p. 2) In high school this interest progressed to collecting bones and dead animals and cleaning them with solvents. Years later, after embarking on his murder career, he developed an extensive collection of human body parts and cadavers, and had mastered details of anatomy and dissection. His collection he viewed as ". . . endowed with existential and sexual meaning. Therefore, to JD it would have been unusual, if not unthinkable, to abandon a human cadaver that he happened to like." (p. 2) The deviant interest in cadavers included both necrophilic and cannibalistic behaviors.

These behaviors were accompanied by other impairments, including failing at college not because of intellect, but because of his narrow range of interest. Compulsive masturbation appeared before adolescence, with later appearance of exhibitionistic behaviors. However, he preferred live sexual partners and only resorted to killing them in order to make them more compliant and predictable as things or objects. Dahmer commonly committed the murders under the influence of alcohol. He had established a pattern of alcohol abuse from his early-adult Army days, and his adult life was complicated by depressed mood, suicidal ideation, and low self-esteem.

Silva, Ferrari, and Leong assigned DSM-IV Axis I diagnoses of Asperger's disorder, Paraphilia not otherwise specified (necrophilia), Alcohol Abuse, and Depressive Disorder Not Otherwise Specified, and Axis II diagnoses of Personality Disorder Not Otherwise Specified (with antisocial, schizoid, and schizotypal personality disorder traits) (2002, 5).

## Brief Historical Context

Since the founding of the asylum, the prison, the juvenile court, and schools for "idiocy," the institutions of caring for the socially marginal or deviant in the United States have often addressed overlapping populations. Indeed, the term (social) "deviance" can be used to refer to these populations of people collectively. Overlap between the populations of the mentally ill, the criminal, and the intellectually impaired has been substantial for the past 125 years both in the United States and much of Western Europe (Foucault 1965, 1977; Foucault et al. 2003; Morse 1998; Porter 2006; Porter and Teich 1994; Rafter 1997; Rothman 2002a, 2002b; Oosterhuis 2000; Scull 1981, 1989; Wright and Digby 1996). Moreover, the development of classifications for deviance has been a common, although perhaps waxing and waning, thread through these institutions over the past century of their development. Classification for these institutions and practices served multiple functions: accounting of the client base; sorting of clients for eligibility; development and specialization of facilities and services; selection and staging of rehabilitative, treatment, and educational services; prediction of relapse or recidivism; and the assembling of statistics for financial, political, and public policy purposes (Blashfield 1984; Costello and Angold 2001; Grob 1983; 1994; Morris and Rothman 1995; Rafter 1997; Rothman 2002a, 2002b). Historical and social science studies of these "institutions for deviance" indicate that,

in their beginnings as with today, substantial numbers of clients were served by two or more of these institutions (Costello and Angold 2001; Grob 1983, 1994; Morris and Rothman 1995; Prins 1990; Rafter 1997; Rothman 2002a, 2002b). These facts alone raise the following questions: Are classifications doing their jobs adequately? Are public policies and services delivering effective and economical care? Are the subject populations parsed appropriately? Although these questions are colossal ones, one facet narrows the scope and focus to a range of questions suitable to philosophical deliberation: the relationship between concepts of vice, mental disorders, and [diagnostic] classification. For simplicity's sake, I abbreviate the vice–mental disorder relationship as VMDR.

## Conceptual Confusions About VMDR in DSM-IV-TR

The DSMs have been the official diagnostic classifications for American psychiatry and as such offer standard concepts for scientific research into mental disorders, pose the basic nomenclature for mental health practice, and provide the public, lawmakers, and policymakers a fundamental language and understanding of mental illness (Frances et al. 1995; Sadler 2002, 2005). However, the DSMs, while presenting a powerful sociocultural influence, also reflect historical, legal, and social forces within and outside the mental health field. The historical context briefly summarized refers to those influences, but the focus of this philosophical case conference main article does not permit much elaboration of them. It may suffice to say that the DSM is both the product of these social forces as well as a contributor to the social shape of mental health care.

The DSM has not systematically addressed the relationship between vice (criminality and wrongful conduct) and mental disorders since DSM-I's inception (APA 1952). As a result, the relationships between vice and mental disorder concepts have been haphazard, contributing to confusing professional and social policy. By way of background, the DSM has been developed by committees nominated by the APA governance, and particularly in recent editions the DSM effort has been coordinated with the World Health Organization's ICD diagnostic classifications to ensure a measure of compatibility between the American and international systems (Frances et al. 1995). Since DSM-III (APA 1980), the efforts to produce a DSM have involved a growing number of committees, professional and lay input, and more systematic efforts to reflect the evolving scientific knowledge and myriad conceptual issues facing an ambitious enterprise—to produce a diagnostic manual for clinical, research, administrative, and educational use (Sadler 2005).

In understanding the confusing relationships between vice and mental disorders in the DSM-IV-TR, one can sort the issues into four broad groups: (1) inconsistencies (omissions, commissions) in how wrongful conduct is classified, (2) impoverishment of DSM criteria sets involving criminal or wrongful conduct, (3) nosological hierarchical and comorbidity issues involving relationships between symptoms and syndromes in DSM-IV-TR, and (4) metaphysical ambiguities around the relationship of vice to illness.

### Inconsistencies in How Wrongful Conduct Is Classified

The DSM-IV-TR continues to reflect the numerous paradoxes about vice and mental disorder that have appeared in earlier editions (APA 1952, 1968, 1980, 1987, 1994) and for this reason the primary focus here will be on this latest edition of the DSM. The central paradox about vice and mental disorder in the DSM involves inconsistencies in the classification of mental disorders involving morally wrongful or illegal behaviors.

Some disorders, for example, Conduct Disorder, illustrated by Case 1 ("I'm Not Right Up Here") are largely defined (through the formal diagnostic criteria) in terms of clinical behaviors that are simultaneously wrongful (and frequently illegal) acts. The DSM-IV-TR Diagnostic Criteria for Conduct Disorder are listed in Table 1. Examination of the diagnostic criteria for Conduct Disorder reveals that, arguably, every criterion describes vice (in my technical sense) under Western cultural conventions, and the majority of the criteria describe frankly criminal conduct, with variances depending on jurisdiction. The ubiquity of vice

language in the DSM-IV-TR Conduct Disorder criteria makes it an exemplar in the confound between vice and mental illness.

Case 2, concerning proxy factitious illness, poses an interesting variation. Here the case presents a mother, Miss A, endangering the life of a child in what must appear to a layperson as both a sick behavior and a criminal assault on a child. The rich contextual information provided by the case authors poses a puzzling mix of sick and wrongful conduct.

When we turn to the "Paraphilias" superordinate category of disorders in the DSM-IV-TR, there are additional examples of vice-laden categories. The DSM-IV-TR Paraphilias that include a direct transgression against another person (a victim) would qualify for criminal prosecution in most US jurisdictions, and these disorders (Exhibitionism, Pedophilia, Frotteurism, and Voyeurism) indeed are commonly seen in forensic settings instead of mental health settings (Abel and Osborn 1992; APA 2000). Case 3, "Jeffrey Dahmer," illustrates an extreme criminal example of an individual meeting criteria for a Paraphilia Not Otherwise Specified (necrophilia). However, as Silva, Ferrari, and Leong (2002) point emphasize, Dahmer's phenomenological clinical profile requires multiple DSM diagnoses.

The contrast of Phillip's (Case 1) Conduct Disorder and Dahmer's multiple DSM diagnoses illustrates another paradox about the DSM classification and vice: We have disorders that exhaustively describe criminal behavior patterns (e.g., Conduct Disorder, Antisocial Personality Disorder) and vice-laden behavior patterns that have eluded straightforward DSM diagnosis, as with Dahmer's case (e.g., arson [Dolan, Millington, and Park 2002; Geller 1992; Lindberg et al. 2005; Ritchie and Huff 1999; Yesavage et al. 1983], serial rape [Bowie et al. 1990; Eccles, Marshall, and Barbaree 1994; Fernandez and Marshall 2003; Yarvis 1995], serial and sexual homicide [Fox and Levin 1998; Malmquist 2006; Warren, Hazelwood, and Dietz 1996], stalking [Kurt 1995; Lewis et al. 2001; Meloy and Boyd 2003; Meloy and Fisher 2005; Rosenfeld 2003]). I refer to this contrast between leaving-in and leaving-out vice in categories as *omissions* and *commissions*. The DSM and vice includes both omissions and commissions.

Other categories with vice-laden diagnostic criteria include Oppositional Defiant Disorder, Borderline Personality Disorder, Kleptomania, Pyromania, Intermittent Explosive Disorder, and Pathological Gambling. (See discussion below for the issues about determining what qualifies as a vice-laden category.) The criteria set for each of these disorders are not listed here for space reasons, but can be viewed in the DSM-IV-TR (APA 2000). Case 2 offers still another perspective, where the conduct of the parents does not frankly present criminal conduct (at least in most US jurisdictions [Sadler 1987; Waller 1983]) yet "Factitious Disorder by Proxy" is a provocative diagnosis for a set of behaviors that criminally exploits children and defrauds health services. Factitious disorders are indirectly vice laden. Other diagnostic categories may also, arguably, be added to the "vice-laden" list, perhaps lending another discussion point for commentators.

In contrast, other mental disorders in the DSM are mostly, even entirely, characterized without reference to any morally wrong or criminal behaviors, at least within Western cultural conventions about wrongful conduct. Schizophrenia, for example, although representing substantial social deviance by any account, features a diagnostic criteria set presenting no vices, with the possible exception of "avolition," which could be construed as laziness or sloth by some. The DSM-IV-TR Diagnostic Criteria for Schizophrenia are listed in Table 2.

These problematic categories represent commissions of vice into diagnostic categories of mental illness. But potential abounds for *omissions* of vice in mental illness categories, if one is ready to admit or "medicalize" (Conrad 2007) new categories of vice or criminal misconduct into categories of mental illness. The general question is this: Why are some categories of criminal misconduct classified as mental illnesses (e.g., child molesting/Pedophilia) whereas other categories of criminal misconduct are *not* classified as mental illness? Some crime-related behavior patterns are classified into the DSM, others are not. For instance, some proposals for vice-laden behavioral syndromes like "Sadistic Personality Disorder" (APA 1987)

Table 2. DSM-IV-TR Diagnostic Criteria for Schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
   (1) delusions
   (2) hallucinations
   (3) disorganized speech (e.g., frequent derailment or incoherence)
   (4) grossly disorganized or catatonic behavior
   (5) negative symptoms, i.e., affective flattening, alogia, or avolition
   *Note:* Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.
B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

*Classification of longitudinal course* (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):
*Episodic With Interepisode Residual Symptoms* (episodes are defined by the reemergence of prominent psychotic symptoms); *also specify if: With Prominent Negative Symptoms*
*Episodic With No Interepisode Residual Symptoms*
*Continuous* (prominent psychotic symptoms are present throughout the period of observation); also specify if: *With Prominent Negative Symptoms*
*Single Episode In Partial Remission;* also specify if: *With Prominent Negative Symptoms*
Single Episode in Full Remission
Other or Unspecified Pattern
(From APA 2000, 312–313.)

and "Paraphilic Coercive Disorder" (serial rapism) have been rejected as categories (Fuller, Fuller, and Blashfield 1990; Kafka 1991), whereas newer proposals like "pathological bias" (racism/hate crime as a mental disorder [Bell 2004; Dunbar 2004; Vedantam 2005]) have yet to appear as official categories. One wonders about where criminal syndromes like serial murder, stalking, and serial arson, to name a few, fit into a classification of mental disorders. Yet a substantial literature exists for biomedical studies of criminal behavior (see Brennan and Raine 1997; Fishbein 2000; Kiehl et al. 2004; Raine 1993; Rowe 2002; Patrick 2006 for reviews) that suggests that biomedicine may offer contributions to the understanding of criminality. Furthermore, other than the modifier "with adult antisocial behavior" and "with disturbance of conduct" for adjustment disorders (APA 2000),

vice-laden behaviors are not included as modifiers or subtyping of DSM-IV-TR disorders.

### Impoverishment of Some Criteria Sets for Vice-Laden Disorders

Consider the DSM-IV-TR diagnostic criteria for Pedophilia (Table 3) with that of Schizophrenia (Table 2). First, the contrast between the detail, length, and breadth of the clinical phenomena for Schizophrenia and Pedophilia are markedly different. By comparison, the Schizophrenia category has numerous and distinctive symptoms, a requirement for social/occupational impairment, duration criteria, distinctions from related disorders, and numerous qualifiers regarding the course and subtypes, the latter with their own sets of diagnostic criteria. The Pedophilia diagnostic criteria are impoverished in comparison (the other Paraphilia diagnostic criteria sets are comparable in their brevity; see APA 2000). Examination of the Schizophrenia criteria also reveals distinctively psychological symptoms relatively immune to misconstrual as vice; comparison with the Conduct Disorder criteria reveals a relative impoverishment of psychological features and an almost exclusive focus on criminal behavior. Why should a disorder like Pedophilia, involving criminality, be impoverished descriptively compared with numerous other DSM disorders? Such an impoverishment only contributes to the impression that Pedophilia the mental disorder is de facto equivalent to the sex offense. When we examine the (research appendix) diagnostic criteria for Factitious Disorder by Proxy (Table 4 [adapted from APA 2000]), we find a similarly impoverished criteria set, essentially describing the transgressive behavior and motive of the perpetrator, Miss A, as in our Case 2.

Yet, in DSM-IV-TR, the phenomenological impoverishment of vice-laden disorders is not universal. The Substance-Related Disorders are often implicated with illegal behaviors (APA 2000, 191–295), but their criteria sets include the nuanced clinical descriptions, exclusion criteria, and subtyping characteristic of classic mental disorders like Schizophrenia, the bipolar disorders, and Major Depressive Disorder. Other DSM impulse control disorders like Kleptomania and Pyromania, although clearly vice laden, exhibit a classical behavioral dyscontrol psychological pattern: emotional arousal, escalating tension, indulgence in the symptomatic behavior, followed by relief of the emotional tension (APA 2000, 669–671). A third category involving intermittent aggressive, even violent, outbursts (Intermittent Explosive Disorder) exhibits a return to the descriptive impoverishment and short criteria set (APA 2000, 667).

The phenomenon of vice-laden but impoverished criteria sets may have a variety of explanations. First, this phenomenon suggests that the category may be heterogeneous in terms of phenomenology, etiology, and even comorbidity. Indeed, one of the functions of the syndrome description in classical medicine was to narrow the diagnostic field so that the diagnosed case truly resembles other cases meeting the syndrome description (Blashfield 1984; Gorenstein 1992; Murphy 1979; Sadler 2005). A "syndrome" describing one or two general phenomena (e.g., fantasies about sex with children, molesting acts) is likely to capture a broad range of dissimilar individuals. Indeed, there is good empirical evidence for phenomenological heterogeneity in populations of "pedophiles" (Galli et al. 1999; Greenberg, Bradford, and Curry 1996; Langevin 2006; Langevin, Curnoe, and Bain 2000; Langevin et al. 1999; O'Donohue Regev, and Hagstrom 2000; Yarvis 1995). Second, the impoverishment of diagnostic criteria sets may simply reflect the state of knowledge about the category (e.g., little knowledge) and/or the proportionate scientific interest in studying the pedophilic phenomenon. Third, the impoverishment may reflect the relative autonomy of the DSM Work Group structures, combined with a lack of consensus within the DSM leadership about the minimum requirements for an acceptable set of descriptive criteria for a mental disorder category. Regarding the former point, the DSMs are built by a diverse group of committees (Work Groups) that focus on a set of disorder categories that are grouped on the basis of phenomenological resemblances (APA 2000). Such committees, working in large part independently, may build categories based on different consensus about fundamental taxonomic issues (e.g., more categories/fewer categories, sharper boundaries/

Table 3. Diagnostic Criteria for 302.2 Pedophilia

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.
*Note:* Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify if:
Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both

Specify if:
Limited to Incest

Specify type:
Exclusive Type (attracted only to children)
Nonexclusive Type

(From APA 2000, 572.)

Table 4. Research Criteria for Factitious Disorder by Proxy

A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.
B. The motivation for the perpetrator's behavior is to assume the sick role by proxy.
C. External incentives for the behavior (such as economic gain) are absent.
D. The behavior is not better accounted for by another mental disorder.

(From APA 2000, 783.)

fuzzier boundaries, more criteria/less criteria, more subtyping/less subtyping). For instance, and as a speculative example, it may have turned out that the Sexual and Gender Identity Disorders Work Group were "lumpers" not "splitters," preferring more encompassing, broad taxons than narrowly constrained, sharply defined categories (Frances et al. 1991), resulting in criteria sets that I call "impoverished." Finally, the impoverishment of categories may be related to the relative absence of co-occurring symptoms/signs; for example, Pedophilia may have little in the way of characteristic symptoms outside of fantasies and molesting behaviors. However, such absence of empirical correlates suggests that the category is inferior in potential for establishing construct or other types of validity (Cronbach and Meehl 1955; Gorenstein 1992; Robins and Guze 1970).

## Hierarchical and Comorbidity Issues

Another perspective on the VMDR pertains to how, and in what ways, signs and symptoms are sorted into meaningful criteria sets. Within DSM-IV-TR Axis I categories, two systematic, encompassing commitments to diagnostic hierarchies are used. One is that symptoms believed to be causally related to substance abuse behaviors are always diagnosed secondarily, for example, Psychotic Disorder due to Amphetamine Abuse. The other is that symptoms believed to be causally related to "general medical conditions" (e.g., "physical" medical or surgical illnesses) must be diagnosed secondarily also (e.g., Personality Change due to a Closed Head Injury). More informally, for many DSM-IV-TR disorders, a diagnostic criterion requires that the condition must be "not due to another disorder." Outside of these specifica-

tions, most of the DSM-IV-TR Axis I disorders are taxonomically parallel; that is, if a patient meets criteria for two or more disorders, then you diagnose both disorders. Case 3, Jeffrey Dahmer, illustrates this vividly, as he carried, according to Silva, Ferrari, and Leong (2002), four DSM-IV Axis I diagnoses. The nosological problem with multiple and parallel diagnoses (comorbidity) with uncertain validity is that the comorbidity may be an artifact of taxonomic mistakes rather than the presentation of multiple truly independent conditions. So if comorbidity is common among the "vice-related" DSM categories, we might suspect that these disorders, such as they are, may be more fruitfully classified in alternative ways. For instance, could it be that Conduct Disorder, or Pedophilia, represents a complication, or variation, on other primary conditions, and if so, these disturbances should be classified as secondary conditions, or perhaps subtypes (e.g., "with disturbance of conduct" or "with paraphilic behaviors"). If such was the case, we would expect that the current DSM-IV-TR disorder categories would have a variety of comorbidities associated with the target condition. Is this the case?

Space does not permit a review, but in considering Conduct Disorder and Pedophilia as examples, there is certainly room for concern about the issue of misclassification of these behaviors. For Conduct Disorder, the literature on comorbidity is large and has been recently reviewed by Angold and Costello (2001). Most notable in their review was the commonality of comorbidity with Attention-Deficit Hyperactivity Disorder as well as substance abuse disorders, but these authors also noted that a prospective, epidemiological study addressing the hierarchical relationships between these three disorders has yet to be done. Similarly, recent studies indicate high degrees of comorbidity for Pedophilia (APA Task Force on Sexually Dangerous Offenders 1999; Frohman, Frohman, and Moreault 2002; Cohen et al. 2002; McConaghy 1998, Raymond et al. 1999; Simon 2000). Criminology literature notes that pedophilic behavior is a substantial risk factor for other sex offenses and other crimes (see Lieb, Quinsey, and Berliner [1998] for a review). Of course, the presence of comorbidity does not prove taxonomic errors, especially in the absence of an etiological basis for the taxonomy, as is the case with the DSMs' descriptive approach. Comorbidities can equally signal selective vulnerabilities for one disorder toward another, expressions of particular social or economic conditions, or a host of other explanations. Whether vice-laden conditions like Conduct Disorder or Pedophilia should be reclassified as complications or subtypes of other disorders is an open nosological question.

An hierarchical issue also related to impoverished diagnostic criteria concerns clinically "loud" symptoms. A "loud" symptom is one that garners immediate clinical and social attention—loud symptoms are often, perhaps usually, identified by others, are vigorously attention getting, and are a common reason for clinical referral. "Soft" symptoms are one that are less apparent, less attention getting, and more subtle, requiring active clinical searching, trained observation, and formal testing. As one might imagine, a descriptively based clinical diagnostic system may end up favoring category building around loud symptoms rather than soft or softer symptoms, especially when etiological, validity, and epidemiological knowledge is scarce. A descriptive classification designed to be user friendly and use a minimum of technical descriptors, as the DSMs are (Frances, First, and Pincus 1995), would be particularly prone to overemphasizing loud symptoms in selecting diagnostic criteria. Childhood misconduct, impulsive aggression, and child molesting would surely qualify as loud symptoms. Building categories around loud symptoms may lead nosologists to overlook potential secondary disorder relationships. Already noting the comorbidities for Conduct Disorder and Pedophilia, perhaps these categories represent a selection bias for loud symptoms, when the epidemiological evidence could favor casting them as expressions of more fundamental disorders of impulse control, excessive biological drives, or other frames of nosological reference (Fishbein 2000; Kafka 1991, 1997, 2003; Lieb, Quinsey, and Berliner, 1998; Raine 1993, 2001; Studer, Aylwin, and Reddon 2005).

## Metaphysical Ambiguities

Explaining or understanding vice-laden behavior (as with any species of human behavior!) requires certain philosophically fundamental kinds of assumptions and commitments. These kinds of assumptions and commitments are "metaphysical" because they concern the nature of being human (ontology) and/or how we are to gain knowledge (epistemology). Metaphysical assumptions and commitments are ambiguous because they require a particular kind of philosophical scrutiny to detect, and competing metaphysical viewpoints may apply powerfully to our social world yet have important areas of incompatibility. Perhaps a paradigmatic example of these metaphysical tensions concerning the VMDR is the question whether the conditions discussed in this article are moral kinds or natural-medical kinds. Are the "patients" involved in our sample cases involved in sick behavior, immoral behavior, both, neither, or some other metaphysical kind altogether?

Some of the metaphysically relevant discussions of the VMDR take polar extremes: Thomas Szasz could be characterized as taking a "moralization" view of vice through his belief that any misconduct should be handled through institutions whose social role addresses moral conduct: the criminal justice system, the education system, or religious institutions (Szasz 1961). For Szaszians, medicine should not address moral conduct—hence my "moralization" characterization of a Szaszian vice account. For Szaszians, the DSM-IV-TR confounds between vice and mental disorder would be further evidence of the category error of "mental illness," and the associated practices associated with "mental illness" would be metaphysically bankrupt because they represent moral, not medical, metaphysical categories (Sadler 2005).

The counterpoint to the moralization account of vice would be the "medicalization" account, where all problematic deviance reflects human illness or injury, including criminality and "immoral" conduct. In contrast to Szaszians, criminal deviance or "Sadlerian" vice, under a "medicalization" account, would be assimilated into the list of maladies suffered by people (Conrad 2007). Adrian Raine, one of the foremost researchers in the psychopathology of criminality, in my view takes a "medicalization" position when he writes:

> Criminal behaviour may be best construed as a neurodevelopmental disorder that arises early in life from a joint product of genetic, biological, and social forces, with conduct disorder as the age-appropriate manifestation of the adult outcome. (2001, 306–307)

It should be noted that Raine's view is not reductionistic in the sense that he believes in genetic or neuroscientific determinism in criminal conduct. Rather, his metaphysical view is that criminal behavior encompasses the realm of disordered or sick behavior.

From the evidence presented in this article, it seems that the DSM-IV-TR takes an amalgamated approach to the metaphysical question of vice as sick or wrongful: either "both" or sometimes one or the other. As I've said in *Values and Psychiatric Diagnosis* (2005), the DSMs are not the product of metaphysical deliberation and theorizing but rather the expression of what might be called "folk metaphysics"—an amalgam of metaphysical assumptions that are more-or-less socially conventional, and represent a loose, informal consensus of the profession. However, the analysis, by philosophers of psychiatry, of these folk metaphysical assumptions can be helpful in understanding nosological problems.

The only formal proclamation from the APA I could find relevant to the question of the medicalization of criminality is from this news release on the Pedophilia diagnosis from June 17, 2003:

> Pedophilia, included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) since 1968, continues to be classified as a mental disorder. . . . An adult who engages in sexual activity with a child is performing a criminal and immoral act and this is never considered normal or socially acceptable behavior. (APA 2003, my editing)

Our social/cultural institutions today, including the DSM-IV-TR, seem to exhibit a varying mixture of the medicalization and moralization accounts. The accounts are a mixture because social policy, procedures, and practices often reflect both, and the mixture is "varying" because historical, geographic, and contextual fluctuations occurs within the expressions and behavior of the law, mental health, and the criminal justice systems. Any folk

metaphysics would fluctuate with culture, subculture, and history. For the VMDR, the manifestations of this "varying mixture" of the two accounts are exemplified by many familiar cultural tropes about mental illness and crime:

1. the controversy surrounding the insanity defense, where we struggle with whether criminal conduct should be excused on the basis of mental illness;
2. in a related fashion, we struggle with questions about what kinds of mental stress or duress undergird legal justifications for otherwise illegal conduct;
3. overlapping populations of people are served by the mental health, criminal justice, intellectually impaired, and homeless relief organizations;
4. stigmatizing of the mentally ill and wrongdoers persists, seemingly on an equal opportunity basis;
5. debate over which institutions should be responsible for the criminally mentally ill;
6. disputes over the social role of psychiatry—as the protector of the public, or as doctor to the ill; and
7. last but not least, the categories of mental disorder in our classifications freely mixing vice with illness concepts, as well as professional psychiatric policies and viewpoints reflecting this mixture.

In practical terms, the metaphysical ambiguities raised by the VMDR mean that the issues are not ones owned by a single set of institutions or disciplines—multiple institutions and intellectual disciplines are involved. One can readily discern a role for history, criminology, penology, other social sciences, law, philosophy, and of course, clinical psychology and psychiatry.

## Questions

### Historical Intractability

The confounds of the VMDR among our social institutions are longstanding. Historians and social critics (referenced earlier) have noted the repeated efforts to reform the lot of the vice-laden deviant (e.g., the mentally ill, the delinquent, the criminal, the intellectually impaired), yet in many historians' views, the problems recur and persist. What lessons does history offer us for the VMDR, and how can we not repeat past mistakes (at least vis á vis diagnosis and classification)?

### The Goals of Psychiatry

Can/should psychiatry and the mental health field "take a stand" about a proper VMDR? What would it consist of? Can a strict medicalization account be defended? Can a strict moralization one be? Perhaps more difficult, can a version of a mixed account be defended? Can a novel formulation be proposed? What should be the role of mental health services vis á vis crime and misconduct? How would we classify our concepts?

### Taxonomic Questions

Many of these issues have been introduced in the foregoing discussion. Should the confound between vice and illness be addressed in the DSMs and ICDs? If so, how?

### Implications for the Criminal Justice System

A sorting out of the VMDR would have implications for the criminal justice system. What are they? Under what metaphysical account? For instance, what might happen to the practice of criminal reform and rehabilitation if criminality was "de-medicalized"?

### Implications for the Law

The vice–mental disorder relationship and its confounds relate profoundly to mental health law and the courts, from the forensic disclaimer in the recent DSMs (Shuman 1989, 2002), to the appearance of "new excuse defenses" in the courts (Delgado 1985; Grier and Cobb 1968; Morse 1998; Sacks 1994) to the appearance of "sexual predator laws" (APA Task Force on Sexually Dangerous Offenders 1999; Lieb, Quinsey, and Berliner 1998). What bearing do the VMDR confounds have on criminal law? How do VMDR confounds interact with concerns of criminal excuse, culpability, justification, therapeutic jurisprudence, and sentencing?

### Ethical and Political Implications

Should social institutions for the deviant exhibit the kind of redundancy of services we currently see? Can a social policy of medicalization (or moralization) be morally justified? What role should psychiatry and the mental health field play in developing social policy concerning the VMDR? What role does the classification of mental disorders play in social policy concerning crime

and misconduct? What role should classification play in services for the mentally ill, the juvenile delinquent, the criminal, and the intellectually impaired?

In conclusion, I hope I have made the case that the vice–mental disorder relationship poses important conceptual questions for the mental health field and beyond. I look forward to the commentaries.

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