Mental disorder and mental health interventions for children and youth: the cases of non-suicidal self-harm and unruly behaviour

A philosophical inquiry

By

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Thesis abstract

This dissertation is a contribution to the philosophy of mental disorder with a focus on children and youth and questions about what interventions they need.

I start by asking whether non-suicidal self-harm in youth is a mental disorder. Non-suicidal self-harm involves someone causing themselves harm with no intent to try to kill themselves. Young people cutting themselves alone and when with peers may be viewed as destructive, abnormal and irrational. Yet, I argue that non-suicidal self-harm in youth is never a mental disorder in its own right. Although non-suicidal self-harm in youth is not a disordered behaviour, that does not imply that it never merits intervention.

This leads to the question of what criteria should be applied when deciding whether to offer mental health interventions. I claim that whether one has a mental disorder should not determine whether one is offered a mental health intervention. The argument is made through considering the cases of non-suicidal self-harm in youth and unruly behaviour in children and youth. Unruly behaviour includes a wailing toddler, a child deliberately breaking items and a youth crossing police lines when protesting.

Unruly behaviour is another interesting case. In some instances, there is a high likelihood of negative outcomes for some children and youth who are behaving in an unruly way. However, unruly behaviour may also be part of a passing phase and helpful for development. Furthermore, in some cases, unruly behaviour may be praiseworthy, and encouraging unruliness may advance an individual's welfare. The case of unruly behaviour, then, raises the question of when mental health clinicians should intervene.

The cases of non-suicidal self-harm and unruly behaviour help make my central claims. I say that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are not mental disorders; that managing life in the best way one can with the abilities available at a particular stage of life is not disordered;

and, furthermore, that whether one has a mental disorder should not determine whether one is offered a mental health intervention. Finally, I say that, rather than depending on whether a person has a mental disorder, interventions should be offered only when they will advance the welfare of the service user.

My dissertation will appeal to philosophers. I also hope that youth, parents, teachers, clinicians, policy makers and similar will be interested in the contents. This is because important practical questions are asked that challenge common views, and that guide policies and clinical practice to improve the welfare and service outcomes for children and youth.

Contents

Introduction

Imagine you are a clinician working for child and adolescent mental health services. Your service is often referred to as "CAMHS". It is a specialist, secondary mental health service and may also be known as "infant, child and adolescent mental services", "infant, child, adolescent and family services" or "the clinical team".[1]

During the morning you join some of your colleagues to screen the referrals that have been made to the service. Your colleagues helping screen the referrals today are a mental health nurse and a psychiatrist. The majority of the referrals are made by adults, such as parents, teachers, community social workers, general practitioners, on behalf of the child or youth. Sometimes youth refer themselves, though that is rare. All the information for each referral is presented on a form. Either the form is completed by the referrer or the information is collated over the telephone by a clinician working for child and adolescent mental health services.

The referrals are for children and youth who are experiencing a variety of concerns. There are concerns about emotions, such as overwhelming sadness, crippling fear and uncontrollable anger. Some of the concerns are about thought patterns, such as suicidal thoughts or thinking they are being persecuted despite the lack of evidence. The information

[1] The infant, child and adolescent mental health services is often referred to as "ICAMHS", and "ICAFS" is commonly used for the infant, child, adolescent and family services. The title "clinical team" may be used when referring to government health funding. For instance, a school or foster home may apply for dedicated health sector government funding to contract mental health clinicians to offer specialist interventions.

on the referral forms also include concerns about behaviours, such as soiling, self-harm or violence towards others.

As part of the team screening the referrals, it is your job to decide on one of three outcomes for each referral. One outcome is to accept the referral and ask the administrator to arrange an appointment for the child or youth to be assessed by the service. Another outcome is to contact the referrer to find out some further information. Lastly, the team may decide to decline the referral and offer other ideas for assistance, such as self-help resources or a community resource, for example a mentoring programme.

As your team works through the referrals you notice that the more frequent referrers are using certain wording on the referral forms. For example, a general practitioner states that in their view, a young person has a "major depressive disorder". Another example includes a teacher who describes a child having symptoms that meet the diagnostic criteria for a severe anxiety disorder. The wording on the referral form from the teacher appears to have been taken straight from diagnostic manuals. You wonder whether indicating the clear presence of a mental disorder is an attempt to ensure acceptance of the referral. [2]

This is a "composite case".

"Composite cases"

[2] In the mental and physical health literature, and from my clinical experience some distinguish between "illness", "disease", "condition", "disorder" and other similar terms. However, in this dissertation, the term "disorder" covers all these different terms. I say a little more about this point in appendix one. In this appendix the reader will also find some further background and explanations of terminology.

In this dissertation, I will be presenting "composite cases", which include clinical scenarios, like the one above, and individual cases. The "composite cases" are imaginative reconstructions based on experiences from several clinical case sources and the research literature. The clinical case sources I have used are from my work experience.[3] "Composite cases" do not correspond to actual people. The cases have no distinctive or distinguishing details, and pseudonyms are used. Any "composite case" will be identified as such. I do not require ethical approval for the use of composite cases.

The "composite cases" illustrate characteristic cases and themes from the literature and my clinical experience. I also use first-person narratives in this dissertation. The composite cases and first-person narratives are used to illustrate specific points that I will describe in the dissertation. Also, when planning the overall dissertation, my aim was to use composite cases that are representative of a wide range of individuals and circumstances. The methodological devices of composite cases and first-person narratives are standard in this area of research. These devices provide the reader with a vivid sense of the nuanced real-world experience of individuals and the complexity of the situations. Also, rather than describing many complex and individual cases, I use my expertise to draw the reader's attention to factors that are characteristic across a range of cases. Furthermore, composite cases are constructed from different clinical case sources, so the details of individual service users and agencies benefit from remaining confidential. Lastly and importantly, the

[3] My clinical background includes working with children, youth, and their families in the United Kingdom and Aotearoa New Zealand. My clinical experience is from specialist, secondary mental health services and clinical non-government organisations, school-based and private practice.

composite cases allow for a degree of description of the lived experience to be present in this philosophy dissertation.

However, it is important to acknowledge the possible risks of using these methodological devices. There is a risk of unconsciously and consciously constructing composite cases and selecting first-person narratives that only suit the point I want to make. Also, when writing composite cases I may have overlooked details that I then did not include. Additionally, I may have paid too much attention to other details that may have resulted in overemphasis.

The influence of mental disorder

The above composite case illustrates the significance applied to the question of whether a child or youth has a mental disorder. As a team, you act as a gatekeeper to child and adolescent mental health services: the specialist, secondary mental health service. You are asking whether the child or youth described in the referral meets the conditions needed in order to be seen by your service. An indication of a mental disorder acts as a key to contacting the referrer for further information or accepting the referral and progressing to the assessment stage. What the clinicians consider to be mental disorders influences someone accessing government funded interventions through the services. To illustrate further the importance of whether an individual is judged to have a mental disorder, imagine another case in which you are still a clinician working for child and adolescent mental health services.

After a referral has been accepted, the child or youth is invited, with other family members, to an assessment appointment with your service. Sometimes the child or youth will come to their appointment with other adults, such as their community social worker or teacher. Older youth may attend an assessment appointment with a friend or romantic partner, or alone. The child or youth is assessed by a clinician or a group of clinicians. The

assessment may take one or more appointments. The clinician may also contact other people in the child or youth's life to gather further information. After this assessment period the leading clinician discusses the child or youth's case with their colleagues at a meeting.

Imagine you have recently assessed a youth and you are now discussing your assessment findings with your colleagues. At this meeting, a larger team of clinicians is included. Your colleagues include psychiatrists, clinical psychologists, clinical social workers, mental health nurses, family therapists, among others. You are meeting to discuss all the children and youth who have recently been assessed by the service. As with the referrals meeting, there are three possible outcomes. One outcome is to accept the child or youth into the service and offer interventions. Another outcome is to continue the assessment and gather further information. Lastly, the team may decide to decline any further involvement with the service and offer other ideas for assistance. At the meeting you are asked to present your evaluation of the young person you assessed, Luke.

Introducing Luke

Luke is a composite case. Luke is a 15-year-old male. He often threatens his peers and has been known to start physical fights. The fights often result in cuts and bruises to Luke and the other people involved. He has broken his finger once. He has attacked someone with a knife before too. On one occasion at school, he broke a window by throwing chairs. He has been suspended from school many times. He has been caught stealing loose change that he finds lying around. Occasionally, he has been out late with friends and he has broken house windows, scratched cars and spray-painted public benches. Luke's unruly behaviour, which has been occurring for many years, is having a negative impact on many areas of his life, such as the relationship with his parents, his peer relationships and his ability to gain an education.

You would like to accept Luke into the service and offer interventions; however, not all your colleagues agree. An influence on having a child or youth accepted by the service is whether they have a mental disorder. Luke meets the diagnostic criteria for "conduct disorder", which is in diagnostic manuals.[4] Hence, according to a certain view, if a child or youth's unruliness meets the diagnostic criteria for conduct disorder then the child or youth has a mental disorder.[5] However, some of your colleagues do not consider conduct disorder to be a mental disorder, so on their view Luke does not have a disorder.[6] These colleagues want to decline any further involvement with the service and offer other ideas for assistance.[7] The question, then, of whether to offer interventions is often treated as the same question as that of whether someone has a mental disorder.[8]

The preview

In this dissertation I will describe the other influences of the term "mental disorder". The term also influences how others are viewed, how people view themselves, when asking whether to seek help and when wondering what action to take. "Mental disorder" has a lot of power. Yet, there is still no widely accepted agreement on the question "what is a mental disorder?"

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[4] Conduct disorder is discussed in more detail in chapters four and five (pp. 95-98 and pp. 114-123) and appendix two has the detailed diagnostic criteria.

[5] This is the diagnostic criteria view, which is discussed in chapter five (pp. 116-123).

[6] I discuss in more detail the view that the unruly behaviour seen in conduct disorder is not a mental disorder in chapter four (pp. 106-112).

[7] Luke will be presented in chapters five and six again. He was accepted into the service.

[8] The linking of these two questions will be discussed further in chapter three (pp. 87-93).

Following some exploratory research, my question has grown into two questions. There is a significant body of literature on the differing definitions of mental disorder (see Cooper 2013 for a summary of some of the views); however, the question "what is a mental disorder?" is separate from the question "who should be offered interventions from a specialist, secondary mental health service?"

The question of who *should* be offered interventions is the question of when it is good to offer interventions. In the real world, as in the above composite case, clinicians have to decide who would benefit from access to their limited resources. They have to ensure resources are used in the right way so that funding is not wasted and is, instead, directed towards those who most need or deserve it. Clinicians also need to ensure that resources are not used in a way that makes someone worse off. In this dissertation, I claim that having a mental disorder is neither necessary nor sufficient for warranting an intervention from a specialist, secondary mental health service.

The cases of non-suicidal self-harm and unruly behaviour

To answer the questions, "what is a mental disorder?" and "who should be offered interventions from a specialist, secondary mental health service?", I use two cases.

One case is non-suicidal self-harm (hereafter referred to as "NSSH"). NSSH is when someone causes themselves harm with no intent to try to kill themselves. Young people cutting themselves alone and when with peers may be viewed as destructive, abnormal and irrational. Furthermore, arguments are presented in the literature for considering NSSH a distinct mental disorder (see Brausch 2019, 71-72 82-84, and Lengel and Mullins-Sweatt

2013, 940-941 for a summary). Yet, I argue that NSSH in youth is non-disordered.[9] By examining the case of NSSH in youth I am able to offer some insights about mental disorder.

The second case is unruly behaviour. There are many examples of unruliness in children and youth. Examples of unruly behaviour include a wailing toddler, a child deliberately breaking items and a youth crossing police lines when protesting. Unruly behaviour is an interesting case to discuss because it, in its own right, sometimes meets the diagnostic criteria for a mental disorder. However, unruly behaviour may also be part of a passing phase and produce goods of childhood and adolescence. Furthermore, in some cases, unruly behaviour may be praiseworthy, and encouraging unruliness may advance an individual's welfare. The case of unruly behaviour, then, is interesting to explore because it raises the issue of when to intervene for a phenomenon that may, perhaps, be a disorder, or part of a passing phase, may produce goods, and may be praiseworthy and beneficial.

The dissertation journey

First, for my claim about NSSH we need to understand what NSSH is. In chapter one, then, I add to some of the philosophical work on definitions of self-harm, which refers to suicidal behaviour and NSSH. By doing this I am able to provide a working definition of NSSH, which I use in this dissertation. Next, I show that in many cases it is possible to clearly distinguish NSSH from suicidal behaviour. Once I have done this preparation work, I am able to move onto my claim about NSSH.

In chapter two, I argue that NSSH in youth is never a mental disorder in its own right. I make my claim about NSSH by identifying the characteristic features and functions of

[9] In this dissertation, the "child" age range is from birth to less than 10 years old and the "youth" age range is from 10 to less than 25 years old. "Adults" are 25 years old and above.

NSSH in youth and showing that these features and functions are also seen in non-disordered behaviours in youth. Yet, when I say that NSSH in youth is not a disordered behaviour I am not saying that it never merits intervention. The case of NSSH in youth, then, helps me to start undermining the assumption that it is only those with a mental disorder who warrant interventions from specialist, secondary mental health services.

This leads me to ask the question: who should be offered interventions from a specialist, secondary mental health service? To make this question clear I have some work to do. In chapter three I spend some time explaining what "specialist, secondary mental health services" are and I add detail to my definition of "specialist, secondary mental health services". [10] Then I explain an assumption that acts as a prominent answer to the question. The assumption is that it is only those with a mental disorder who warrant interventions from these services.

Next, in chapter four, I explain "unruly behaviour" and "unruliness".[11] Under the term "unruliness" I include different concepts that resemble each other. It is in this chapter that I point out that unruly behaviour may, perhaps, be a disorder, or part of a passing phase, may produce goods, and may be praiseworthy and beneficial depending on the case.

In chapter five, I ask the question: who should be offered interventions from a specialist, secondary mental health service? Here I use the case of unruly behaviour and NSSH to suggest that on *any* plausible theory or definition of disorder, it is not the case that

[10] I have already started to explain "specialist, secondary mental health services" in the composite case above (pp. 1-5).

[11] I have started to illustrate unruly behaviour and unruliness through the composite case of Luke (pp. 5-6).

all those with mental disorders should always be offered interventions from a specialist, secondary mental health service. To make my claim I discuss four prevailing views, from the clinical setting and literature. For instance, one view is that someone who meets diagnostic criteria should be offered interventions. I discuss this view by presenting the diagnostic criteria for "oppositional defiant disorder" and "conduct disorder".[12] I then ask whether these diagnostic criteria determine who should be offered interventions. I show that someone may meet diagnostic criteria and warrant an intervention, and someone may meet diagnostic criteria and *not* warrant an intervention.

In the final chapter, the insights I offer about mental disorder are summarised. I say that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are not mental disorders; that managing life in the best way one can with the abilities available at a particular stage of life is not disordered; and, furthermore, that whether one has a mental disorder should not determine whether one is offered interventions from specialist, secondary mental health services. This leads me to ask what the criteria are for offering interventions from these services.

Hence, in this final chapter, I offer insights on the question: what are the necessary conditions for offering interventions from a specialist, secondary mental health service? I say that, instead of using the presence of a mental disorder as a criterion, interventions from these services should be offered only when they will advance the welfare of the service user. Yet, this condition is not sufficient, so I point to future research that is needed and offer further conditions. I then explain why I apply my insights to mental disorders and not physical disorders. I end by discussing an overarching theme of this dissertation, which is that we can

[12] The detailed diagnostic criteria for "oppositional defiant disorder" and "conduct disorder" are in appendix two.

make significant progress on philosophical questions about mental disorder and intervention without committing to a particular definition or theory of mental disorder.

The aim of this dissertation

The aim of my dissertation is to challenge common views, and guide policies and clinical practice in ways that improve the welfare of, and service outcomes for, children and youth. This means that my dissertation will not only appeal to philosophers; I hope that youth, parents, teachers, clinicians, policy makers and others will be interested in its contents.

Chapter one: what is non-suicidal self-harm?

Introduction

To illustrate non-suicidal self-harm, consider the first-person narrative of Andrew Lawes (2012, paras. 16–17):

> that was the first night in weeks I didn't want to die. Because, no matter what depression did to me, I could control the bleeding. When I cut, it helped to take away thoughts of suicide.
>
> My body is adorned with the scars of self-harm. But they aren't scars of suicide attempts. They aren't scars of wanting to die. They are scars of wanting to feel alive, and feel in control of the life I had. If I hadn't self-harmed, I might not be here today. But I did, and I am.

In this excerpt from the online media platform, '*The Good Men Project*', Lawes describes a night he engages in non-suicidal self-harm during a period of feeling depressed and having suicidal thoughts. He cuts his skin as a non-suicidal self-harming behaviour. Other non-suicidal self-harming behaviours include biting, scratching, picking at wounds, head banging, hitting oneself or objects, burning skin, taking overdoses, injecting poisonous substances, and inserting objects in orifices or under the skin. However, defining non-suicidal self-harm is difficult. Before I say what I do in this chapter, here are three preliminary terms for clarity.

Preliminary terms for this chapter

"Suicidal behaviour" occurs when someone does something with the intent to kill themselves, whether they achieve this result or not. Suicidal behaviour is an important phenomenon, but it is different from non-suicidal self-harm.

"Non-suicidal self-harm" (hereafter referred to as "NSSH") occurs when someone causes themselves harm with no intent to try to kill themselves, even if they do kill themselves.

"Self-harm" collectively refers to suicidal behaviour and NSSH.

Preview

Non-suicidal self-harm is not a new phenomenon.[13] However, there are different definitions. In this chapter, I add to the sparse philosophical literature on defining NSSH by discussing the problems and limitations of three existing definitions. I then present the working definition used in this dissertation. I end by responding to the philosopher Hanna Pickard's claim that in practice the distinction between NSSH and suicidal behaviour is often unclear. I say that in practice it is not as difficult to distinguish NSSH from suicidal behaviour as Pickard claims. I suggest that it is feasible to clearly distinguish NSSH from suicidal behaviour in many cases by considering four specific questions associated with the behaviour. Considering NSSH separately from suicidal behaviour allows me to draw attention to some important points about NSSH.

Before I continue, let me say what makes for a suitable definition of NSSH. There is a discrete and actual phenomenon of people harming themselves, not with the intent to kill themselves but mainly as a coping mechanism. I am trying to find a definition of this phenomenon, which I refer to as "NSSH". I consider a suitable definition of NSSH to be one that covers all and only the cases that clinicians are likely to regard as being NSSH. Furthermore, the definition needs to have enough detail for clinicians to use to be able to say

[13] For example, a 1960s United States of America Study describes people self-harming to feel better (Graff and Mallin 1967).

whether a certain behaviour is NSSH. Lastly, I consider a suitable definition for NSSH to be one that meets our intuitive understanding of "non-suicidal" and "self-harm". To summarise, then, ideally, a definition of NSSH will cover all and only the cases that clinicians are likely to regard as NSSH, and it will meet our intuitive understanding of the term.

I start by asking whether the first of two definitions from the World Health Organization is able to achieve what I want.

The World Health Organization's first definition

The World Health Organization (Kerkhof, Schmidtke and Bille-Brahe 1994, 7 cited in Pickard 2015, 74) definition states that NSSH is "an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised dosage".

Two problems and the inclusion of "deliberately"

There are two problems with this definition. The first problem is that the definition does not accurately represent many characteristic cases of what clinicians consider to be NSSH. The second problem is that the definition is intuitively wrong.

The first problem is that the definition does not accurately represent many characteristic cases of NSSH because of the inclusion of the word "non-habitual". As Pickard says, the "non-habitual" part of the definition is not accurate because many repetitively engage in NSSH with some even harming themselves daily (Pickard 2015, 74). I support the view that many characteristic cases of NSSH are of a repetitive and habitual nature. I provide evidence for this view by saying that there is literature that shows those that engage in NSSH

will often harm themselves more than once and many will regularly harm themselves (Hasking et al. 2016, 646, Moran et al. 2012, 239-240, and Zetterqvist et al. 2013, 765). To illustrate the habitual nature of NSSH, consider the first-person narrative of Chris (2017, para. 2):

> My confidence and self-esteem was at an all-time low – and with them in the dirt, I started to experience desires to self-harm. It was another problem that quickly grew out of control. I'd go home nearly every night and hurt myself, and then cry myself to sleep.[14]

The second problem is that the World Health Organization definition is intuitively wrong because it states that NSSH does not result in a "fatal outcome". Yet, someone may engage in NSSH without the intent to die but still die. For example, consider the hypothetical case of someone who ingests prescription medication. He takes enough medication to cause himself harm but not to result in death. This is an act he has done previously so he is aware of how many tablets to take without killing himself. However, on this occasion, perhaps due to miscounting how many tablets he has taken, the act does result in death. The act would still be NSSH, which has resulted in an accidental fatal outcome. These are the two problems with the definition.

Now I discuss the inclusion of "deliberately". There is no general agreement about whether the term "deliberately" should be included in a definition. The United Kingdom National Institute for Health and Care Excellence (hereafter referred to as "NICE") does not

[14] Chris describes his behaviour as "self-harm" but from the description I strongly assume he is discussing "NSSH".

use the term "deliberately" in its definition.[15] [16] The NICE guidelines (2004, 16) on the short-term management of NSSH and suicidal behaviour in health care say that "for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance-like', or dissociative, states". This is one reason why the NICE does not use terms such as "deliberate" in its definition of self-harm (NICE 2004, 16). In these NICE guidelines there is no explanation of what counts as a "dissociative state". As a clinician reading these guidelines, I assume a "dissociative state" to be a state in which someone becomes severely disconnected from their thoughts or emotions. A "dissociative state" may also involve the coexistence of different personalities within one person. The different personalities are able to influence his behaviour, but he may experience the encounters as a loss in memory.

The NICE has another reason for not using "deliberate" in its definition. The NICE (2004, 18) say that many people who harm themselves object to the inclusion of terms like "deliberate" and "intentional". [17] The researchers Navneet Kapur, Jayne Cooper, Rory C. O'Connor and Keith Hawton (2013, 326-327) also say "the prefix 'deliberate' has been largely dropped because of concerns that it was judgemental and that the extent to which the

[15] The United Kingdom National Institute for Health and Care Excellence used to be named the "National Institute for Clinical Excellence". For ease I use "NICE" throughout.

[16] I discuss the NICE definition later in this chapter (pp. 21-24).

[17] Pickard also points out that the NICE does not include "deliberate" in its definition. She says this is likely due to "a desire to accommodate forms of self-harm that stem from unconscious or unrecognized motives or impulses, or that may be foreseeable but not directly intended" (Pickard 2015, 74).

behaviour is intentional is not always clear".[18] [19] I have not been able to clearly gauge, from the NICE document and the researchers' paper or the document the researchers reference, why the inclusion of the word "deliberate" has negative connotations for those that harm themselves. However, drawing from my clinical experience, I suspect the word "deliberate" has negative connotations because it suggests that the behaviour is voluntary so the person is choosing to act this way and hence he can choose to stop. This may elicit an unsympathetic response from clinicians, his loved ones and the wider public. He may be considered at fault for his behaviour and this, in turn, may lead to a lack of support or help, if needed. Also, he may be reluctant to tell others that he is harming himself because he thinks he will be blamed so he does not seek out support or help.

Nevertheless, in my view, a definition of NSSH does need to contain the term "deliberate" so that only behaviour that is intentional is included.[20] The reason I give for the inclusion of "deliberate" is to avoid including behaviour that does cause harm to oneself even though harming oneself is not the purpose of the behaviour. For instance, binge drinking causes harm to oneself and that is why people are physically unwell after binge drinking. This behaviour also carries risk such as long-term physical problems and death. However, I suggest that most people do not binge drink intending to cause themselves the harm of being

[18] I discuss the second part of their point, that the intent behind the behaviour is not always clear, later in this chapter (pp. 27-36).

[19] Some of the researchers are also psychiatrists.

[20] I take this position after a lot of consideration. I found this a difficult choice to make in light of the reasons why those that harm themselves may object to the inclusion of "deliberate".

physically unwell or intending to risk long-term physical problems and death. I do not want to include cases like this in a definition of NSSH.

I do want to add that the inclusion of the word "deliberate" is not intended to be judgemental because even though the behaviour is voluntary, the behaviour may be very difficult to control. The psychiatrist Steve Pearce, and Pickard (2010, 831) suggest that some behaviours, including harming oneself, are best viewed as voluntary acts over which the person has some, even if little, control and that he is hence able to change.[21] Pearce and Pickard (2010, 833) say clinicians are able to avoid placing blame on those that harm themselves by considering the reasons why control is reduced and the reasons for the difficulty in changing the harming behaviour, even if this may be difficult for clinicians to achieve.

Hence, there is a need to change the assumptions people make about deliberate behaviour. A change of attitude is needed from clinicians and society as a whole. There are several reasons for the need to change the general attitude. One reason is so that those engaged in NSSH do not elicit an unsympathetic response from clinicians, their loved ones and the wider public. Another reason is so that those engaged in NSSH are not considered to be at fault for their behaviour. My worry with considering those who engage in NSSH as being at fault is that they may not be offered support or help, if needed. Finally, a further reason for a need for a general change in attitude is so that those who engage in NSSH do not

[21] This paper is not about the definition of NSSH but viewing patients, who display a variety of different behaviours, as responsible agents (Pearce and Pickard 2010). The authors discuss a variety of behaviours, such as taking drugs, overeating and harming oneself (Pearce and Pickard 2010, 831).

think that they will be blamed. If they are not blamed, but instead understood, this will hopefully mean they will be more open to seeking support or help, if needed.

The benefit of the World Health Organization definition is the inclusion of the word "deliberately". Yet, as I said, this definition does not accurately represent many characteristic cases of NSSH. The definition says that NSSH is "a non-habitual behaviour"; however, there is a repetitive and habitual nature to many cases of NSSH. Also, the definition is intuitively wrong. The reason the definition is intuitively wrong is that it says NSSH does not have a "fatal outcome". Yet, it may be the case that NSSH does have a fatal outcome.

The World Health Organization's second definition

The World Health Organization's second definition says that NSSH is "self-directed violence". As cited in the World Health Organization's "*World report on violence and health*" (hereafter referred to as "WRoV") (Krug et al. 2002, 5) violence is "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation". The World Health Organization's WRoV (Krug et al. 2002, 6) considers violence directed to oneself to be "self-directed violence" and says "self-directed violence is subdivided into suicidal behaviour and self-abuse. The former includes suicidal thoughts, attempted suicides – also called 'parasuicide' or 'deliberate self-injury' in some countries – and completed suicides. Self-abuse, in contrast, includes acts such as self-mutilation".

Conceptualising non-suicidal self-harm as violence

Some may find it difficult to conceptualise NSSH and suicidal behaviour as violence. Pickard (2015, 71-72) says that society finds it difficult to consider NSSH and suicidal

behaviour as violence for two reasons. The first reason is that the common view of violence is that it is directed at others. She illustrates this by saying the common images of violence are examples of "fights, brawls, muggings, gang warfare, military warfare and perhaps sexual violence and domestic abuse of women and children" (Pickard, 2015, 71). The second reason that Pickard (2015, 71-72) gives is that the common view is that violence is usually carried out by males, so, because research shows females are more likely to attempt suicide and engage in NSSH, society does not consider NSSH and suicidal behaviour to be violence.[22] Pickard (2015, 72) further says that due to not wanting to view women as aggressive, society does not want to perceive women engaged in violence, either to themselves or others.

The two reasons Pickard gives may be reasons why some may find it difficult to conceptualise NSSH and suicidal behaviour as violence. There may be other reasons too. For example, a society may view violence as an aggressive and hostile behaviour that should be

[22] Pickard (2015, 71-72) also says that research shows males are more likely to attempt suicide and there is some evidence to say that rates of NSSH are rising amongst males. In fact, there is research that shows the prevalence of NSSH for males is generally similar to that for females (Kerr, Muehlenkamp and Turner 2010, 240, and Martin et al. 2010, 507). Also, research shows that males say they engage in NSSH for the same reasons as females (Jacobson and Gould 2007, 138, and Martin et al. 2010, 508). However, even if research shows that there is the same rate of NSSH in males and females, Pickard is still able to make her claim because there is still a societal view that females engage in NSSH more than other genders. To illustrate this, see my public opinion piece that responds to the view that NSSH is only a female issue titled '*Females aren't the only ones that self-harm*' (Ahir-Knight 2018). I note that Pickard does not mention that there are more than two genders, but she may say that for her claim she does not need to mention other genders.

stopped. The person committing a violent act may be viewed as a criminal requiring punishment. The same society may view NSSH as a sign of a problem or an understandable and self-soothing behaviour.[23] The person engaged in NSSH may be viewed as requiring support or help. Also, the same society may view suicidal behaviour as indicative of someone wanting to end their painful life or being failed by society. The society may not want to consider those engaged in NSSH and suicidal behaviour as sinful and requiring punishment, unlike the violent person. These may be reasons why some may find it difficult to conceptualise NSSH and suicidal behaviour as violence.

Also, not all acts of NSSH and suicidal behaviour may be viewed as violent in nature. For example, a common view may be that a violent act is one that involves physical force. As Pickard says, most forms of self-harm involve physical force; however, some acts, such as poisoning and taking an overdose, do not (Pickard 2015, 75). Nonetheless, the World Health Organization's WRoV has a broad definition of violence. This definition of violence includes violence that occurs from power relationships, neglect, all types of abuse, and verbal violence such as threats (Krug et al. 2002, 5). Under this broad definition, NSSH and suicidal behaviour are also forms of violence. The World Health Organization's WRoV definition is not one that may be intuitively held and I want a definition that is intuitive, so this is the reason why I am not using the World Health Organization's WRoV definition.

The National Institute for Clinical Excellence definition

[23] In chapter two (pp. 47-49), I discuss the function of NSSH, which is in many cases an understandable behaviour done to manage overwhelming emotions and thoughts.

The National Institute for Clinical Excellence (2004, 16) definition is that self-harm is "self-poisoning or self-injury, irrespective of the apparent purpose of the act".

The puzzling part and a problem

The first point to note is the puzzling inclusion of "self-injury". "Self-harm" and "self-injury" seem to be the same thing, so the inclusion does not say much about the nature of NSSH.

Now, I discuss the inclusion of "irrespective of the apparent purpose". Pickard (2015, 74-75) says "according to this definition, even genuine accidents that inadvertently result in self-injury but belie no unconscious motive and could not have been foreseen will count as self-harm". I note in the NICE guidelines (2004, 18), it says "the suggestion that a person may accidentally self-harm would be misleading: we simply say that the person has had an accident". I assume, then, that the NICE think it is not necessary to rule out accidents explicitly in a definition of self-harm. I think a definition that is based on an intuitive understanding of "self-harm" would not need to explicitly rule out accidents.

A problem with the inclusion of "irrespective of the apparent purpose" is that the definition widens the scope of the behaviours included. Pickard (2015, 74) makes this point and provides examples of phenomena that may be included under the definition, such as eating disorders, substance misuse, getting into fights and contact sports. She says widening the scope of the definition means that behaviour that causes physical harm to oneself and behaviour that likely risks physical harm to oneself is considered self-harm even though harming oneself is not the purpose of the behaviour (Pickard 2015, 74).

The NICE guidelines acknowledge that the definition is broad. As the NICE guidelines (2004, 16) point out, behaviours that are culturally acceptable, such as smoking tobacco, binge drinking and dieting, may cause harm to oneself so fit the definition. The

NICE guidelines (2004, 16) also point out that "self-harm can occur as part of religious practice, as a form of political or social protest or as an act of 'body enhancement'".[24] There are many behaviours that cause physical harm to oneself that would be considered "self-harm", under this definition, even though harming oneself is not the purpose of the behaviour. However, the NICE (2004, 16) says the focus of the guidelines is "those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself". This means, even though there is a broad definition of "self-harm", these guidelines are only for specific types of self-harm.[25]

[24] An example of causing harm to oneself for religious reasons is self-flagellation, when someone will beat and whip their skin. There are examples of people causing harm to themselves as a form of protest, such as reports of campaigners in the United Kingdom cutting themselves to communicate their objection to an Immigration Bill, a woman in Pakistan cutting and beating herself following failed attempts to meet with the President, and those in immigration detention sewing their lips in protest (RT 2015, The Express Tribune 2012, and Fiske 2016, chapter 5 respectively). I assume "body enhancement" includes behaviours such as tattooing, piercing and scarification. Scarification, which is practiced across different cultures, is the act of causing a permanent mark to the body through cutting and branding the skin (Pitt Rivers Museum Body of Arts 2011).

[25] It is interesting to note that the NICE avoids the direct use of "intentional" or "deliberate" in its definition but then states its focus is on cases in which someone "directly intends" to harm themselves. In my view this implies that the use of "intentional" or "deliberate" is difficult to avoid when discussing the nature of NSSH. I discussed the inclusion of "deliberate" earlier in this chapter (pp. 15-19).

The purpose of the NICE guidelines (2004, 11) is to assist clinicians and policy makers in providing and developing health care for those who engage in self-harm. I have no objection to a broad definition of "self-harm". However, the inclusion of "irrespective of the apparent purpose" makes the definition too broad for what I want from a definition of NSSH. For what I want from a definition of NSSH, the purpose of an act needs to be considered so that clinicians are able to say whether a certain behaviour is NSSH. For example, someone may engage in a behaviour, such as taking an overdose, as either suicidal behaviour or NSSH. A clinician needs to consider the purpose of the behaviour to determine whether, in this case, the person is engaging in suicidal behaviour or NSSH.[26] Hence, I will not use this definition as it is too broad to be useful.

The International Society for the Study of Self-Injury definition

The International Society for the Study of Self-Injury (hereafter referred to as "ISSSI") (2019a) is an organisation of researchers, clinicians and community members with the aim of promoting the understanding of NSSH. The ISSSI use the term "non-suicidal self-injury". The ISSSI (2019b, para. 1) definition of NSSH is "the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned".

The ISSSI definition is the most helpful working definition for my purposes. The definition contains the term "deliberate" so that only behaviour that is intentional is included. There is a reference to not including behaviours that have suicidal intent or a social or

[26] I discuss further distinguishing NSSH from suicidal behaviour later in this chapter (pp. 27-36).

cultural purpose. This means the definition is not too broad and narrows the focus to cases that clinicians are likely to regard as being NSSH. Furthermore, features that do not accurately represent many characteristic cases of NSSH are not mentioned. For instance, there is no reference to NSSH being a non-habitual behaviour as in the World Health Organization's first definition (pp. 14-15). The ISSSI definition, then, goes a long way to meet our intuitive understanding of NSSH.

The need for further work

Yet, there is a need for more work. Firstly, the inclusion of "self-inflicted" may need further clarification. To illustrate my point, consider someone inflicting harm to himself by cutting his skin with an instrument, such as glass or a blade. This is clearly self-inflicted. Also, the behaviour of hitting himself is self-inflicted. However, engaging in NSSH by initiating physical fights to cause someone else to inflict physical damage to himself may not be clearly self-inflicted. The question, then, is this: would the definition be clearer if "self-directed" is used rather than "self-inflicted"? This is a question that I leave aside for now.

Also, the definition aims to avoid the inclusion of behaviours that do not directly and immediately cause physical injury; however, this is not explicitly included in the definition (The ISSSI 2019b, point 2). For example, food restriction is not included as a form of physical injury because the physical harm does not happen immediately (The ISSSI 2019b, point 2). Yet, if someone, for example, was binge drinking, smoking tobacco, dieting or over-exercising with the intent to cause themselves harm, then, in my view these cases should be included even if it is indirect and delayed harm.

Furthermore, the definition explicitly only considers NSSH to be "damage of body tissue". This raises a question that needs further detailed consideration. The question is this: does NSSH also include psychological harm? For instance, someone may engage in NSSH to cope with overwhelming feelings and to punish himself. He may engage in physical harm,

such as cutting himself, for these reasons. However, instead, he may engage in psychological harm, such as belittling himself and referring to himself in a derogatory manner, for the same reasons. Is he engaged in NSSH if he is only belittling himself and referring to himself in a derogatory manner, rather than engaging in physical harm? This is also a question that I leave aside for now and, for the moment, I will presume that NSSH only includes behaviours that result in physical damage.

Finally, behaviours that are socially and culturally acceptable, such as tattooing, piercing and scarification, are not included in this definition (The ISSSI 2019b, point 4). I also want to exclude these behaviours because, usually, the motivations behind these acts are different from those found in characteristic cases of NSSH.[27] However, if someone, for

[27] It has been suggested that culturally approved behaviours that involve harming oneself and NSSH may be intended "to correct or prevent a pathological, destabilizing condition that threatens the community, the individual, or both" (Favazza 1989, 142). This point requires detailed analysis. I say that culturally approved behaviours and NSSH do not share the same functions. NSSH is mainly a mechanism for coping with intense emotions and thoughts by providing temporary relief to enable the person to manage life (Hasking et al. 2016, 646, Lewis and Heath 2015, 527, and Moran et al. 2012, 241). This suggests that NSSH is mainly used to promote only the healing of the individual and not the community. Also, from my clinical experience and the literature, other functions of NSSH include to experience a feeling when one is feeling emotionally empty, to feel a sense of connection with oneself, to stop suicidal thoughts and urges, to punish oneself, to communicate one's distress to others (particularly when other means of trying to communicate distress have not been effective), to feel in control, to try out a new behaviour, and to fit in with other peers who engage in NSSH (Hasking et al. 2016, 646-645, Klonsky and Glenn 2009, 215-219, and Lewis and Heath

example, was getting tattoos with the intent to cause themselves harm, then, in my view these cases should be included, and I think the ISSSI would agree. This agreement depends on the meaning of "*purposes* not socially or culturally sanctioned" (emphasis added). The use of "purposes" could just mean "motives".

The working definitions in use in this dissertation

Despite the work needed, the ISSSI definition of NSSH is the most accurate and informative definition and gives what I want from a definition of NSSH. For this reason, the following working definitions are used in this dissertation:

> "Suicidal behaviour" occurs when someone does something with the intent to kill themselves, whether they achieve this result or not.
>
> "Non-suicidal self-harm" (hereafter referred to as "NSSH") is "the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned" (The ISSSI 2019b, para. 1).
>
> "Self-harm" includes suicidal behaviour, NSSH behaviours and other behaviours that may cause harm to oneself, even if that is not the intended purpose.

Distinguishing non-suicidal self-harm from suicidal behaviour

2015, 527). In common understanding, the function of social, religious and cultural forms of harming oneself is different. The function of social, religious and cultural forms of harming oneself include to commemorate deities or show devotion, to display a certain image, to increase sexual attractiveness, to mark maturity, to display one's position of power and to symbolise one's culture.

The ISSSI definition clearly excludes suicidal behaviour because of the inclusion of the qualification "without suicidal intent". The ISSSI (2019b, point 3) says that NSSH is separate from behaviours and thoughts in which the person wants their life to end. I agree; suicidal behaviour is an important phenomenon, but it is distinct from NSSH. I also have the view that it is important to consider NSSH separately from suicidal behaviour.

Not all agree with distinguishing NSSH from suicidal behaviour. For example, some researchers say that distinguishing NSSH from suicidal behaviour based on the intent behind the behaviour is not always helpful or feasible (Kapur et al. 2013, 326-327). The reasons they give are that motivations are not always clear, motivations change during episodes of NSSH, and someone may be engaged in NSSH and suicidal behaviour at the same time (Kapur et al. 2013, 326-327).

Pickard (2015, 75 and 81) also expresses the view that the distinction between NSSH and suicidal behaviour is often unclear. She says:

> Suicide and self-harm can be distinguished in principle via intent: the intention in suicide is to die, while the intention in [NSSH] is not to die, but to damage or harm oneself. However, in reality the distinction between them is often unclear, with people unsure as to what they intend, or indifferent as to the outcome and reckless in method, so that [NSSH] can commonly and knowingly risk death, even if death is not the clear and conscious intention of the act (Pickard 2015, 75).

Pickard thinks NSSH and suicidal behaviour are able to be theoretically distinguished. However, in practice determining the intent, she says, is often difficult. This is due to people who harm themselves expressing uncertainty about intent, being indifferent about a fatal outcome and risking killing themselves. However, I say that in practice it is not as difficult to distinguish NSSH from suicidal behaviour as Pickard claims.

Responding with a "four-question-analysis"

Consider what the researchers Patrick L. Kerr, Jennifer J. Muehlenkamp and James M. Turner (2010, 242) say about how to distinguish NSSH from suicidal behaviour. Kerr and colleagues (2010, 242) say that cases of suicidal behaviour are "most easily differentiated" from NSSH by "intent, method and psychological impact". This means that the intent in characteristic cases of suicidal behaviour is, generally, different from the intent in characteristic cases of NSSH. Also, the methods used in characteristic cases of suicidal behaviour are, generally, different from those used in characteristic cases of NSSH. Finally, the psychological impact in characteristic cases of suicidal behaviour is, generally, different from that seen in characteristic cases of NSSH. Later, the authors point out the repetitive nature of NSSH when discussing how the psychological impact of engaging in suicidal behaviour is, generally, different from the psychological impact of engaging in NSSH (Kerr, Muehlenkamp and Turner 2010, 242). I want to suggest, then, that, by considering the intent behind a behaviour, the method used, whether the behaviour is repetitive and the psychological impact of the behaviour, it is feasible to differentiate suicidal behaviour from NSSH in many cases. I shall refer to this as a "four-question-analysis" to distinguish NSSH from suicidal behaviour.

The first question to ask is this: what is the intent behind the behaviour? There are many people who engage in NSSH who are able to clearly say they are not intending to die or even thinking about killing themselves when they are engaged in NSSH (Kerr, Muehlenkamp and Turner 2010, 242). This means that when someone clearly expresses that the intention behind the behaviour is not to kill themselves, this strongly suggests that the behaviour is NSSH rather than suicidal behaviour. However, occasionally the intent is not clearly expressed by the person engaged in harming themselves. The intent may also change during an episode of harming oneself. This, then, draws into question: what is the intent behind the

behaviour? In these cases, one is then unable to clearly say whether the behaviour is NSSH. Yet, there are still many cases when the intent is clearly expressed as not wanting to die.

The second question to ask is this: what is the method used by the person? Kerr and colleagues (2010, 242) say that most recorded suicides are due to methods of "gunshots, hanging, overdose, self-poisoning, and jumping from lethal heights", and only a smaller percentage are due to cutting. This means that someone jumping from a bridge is likely to be engaging in suicidal behaviour and someone cutting themselves is more likely to be engaging in NSSH. Relying on method alone though poses some difficulties because someone may take an overdose with the intent to kill themselves, and someone else may take the same overdose with no intent to kill themselves. This is why considering the method will sometimes but not always be enough to determine whether someone is engaging in suicidal behaviour or NSSH.

Also, the method used may call into question the intent behind the behaviour. For instance, someone may say they had no intent to kill themselves after, for example, jumping from a bridge. Yet, due to the lethality behind the act of jumping from a bridge, this would draw into question whether the person really did not want to kill themselves. However, from my clinical experience and reading research studies I strongly suspect that this type of case would be extremely rare.[28] The person is more likely to be vague about their intent so the act of jumping from a bridge would be considered suicidal behaviour due to the uncertainty of the intent. However, if in the rare case the person clearly states that they did not intend to kill themselves, the lethality of the act of jumping from a bridge would mean this is a case that one is unable to clearly say is NSSH.

[28] I have not come across a case.

The third question to ask is this: is there a repetitive nature to the behaviour? Many people who attempt suicide have done so previously; however, there is a more repetitive nature to NSSH (Kerr, Muehlenkamp and Turner 2010, 242). This means someone engaged in NSSH is likely to be harming themselves more often than someone engaged in suicidal behaviour. Yet, someone may only engage in NSSH once or twice, so there is no repetitive nature to their behaviour, and someone may repetitively try to kill themselves daily. From my clinical experience and reading the research studies, there are cases of NSSH when the person has tried to harm themselves a few times and then never engaged in the behaviour again (for example, Monto, McRee and Deryck 2018, 1043, and Moran et al. 2012, 238 and 241-242). There are also cases of people repetitively engaged in suicidal behaviour so requiring hospital admissions. Hence, the question of the repetitive nature is only able to help in some cases.

The fourth question to ask is this: what is the psychological impact of the behaviour? The main function of NSSH in youth is to serve as a mechanism for coping with intense emotions and thoughts by providing temporary relief to enable the person to manage life (Chapman, Gratz and Brown 2006, 379-381, and Nock and Prinstein 2004, 889). For many, then, NSSH decreases the negative affect someone is feeling, and the initial result is a positive affect (Kerr, Muehlenkamp and Turner 2010, 242). The psychological impact for someone following non-fatal suicidal behaviour is different. If someone has survived a suicide attempt, they may feel disappointment that they did not die. The result is not a positive affect, but instead, they may feel more depressed and make a further attempt (Kerr, Muehlenkamp and Turner 2010, 242).

However, someone may not gain a positive affect from NSSH, and someone may not gain a negative affect from surviving a suicide attempt. To illustrate this, some engage in NSSH and do not find the behaviour effective at decreasing the negative affect they are feeling. Instead, engaging in the behaviour may make them feel worse. Also, someone may

feel a sense of relief that they survived a suicide attempt rather than depressed. Hence, the question of the psychological impact is only able to help in some cases.

Illustrating the four-question-analysis

In my view, considering only the intent behind the behaviour and method used makes it feasible to distinguish NSSH from suicidal behaviour in many cases. Yet, considering all four questions is helpful, so to illustrate how the answers to all four questions clearly indicate NSSH, consider the composite case of Parker. Parker scraped his arm when he fell from his bike. As the injury started to heal Parker started to regularly pick at the skin with safety pins and his fingernails. He has been doing this most days for a few months now. He reports picking at the sore, which causes physical harm, when he is feeling upset. He describes feeling comforted and better when he picks at the sore. From Parker's description, there is no expression of any intent to die. The method, of picking at skin, is not usually used in acts of suicidal behaviour. There is also a repetitive nature to the behaviour because he says he has been engaging in the behaviour most days for a few months. Furthermore, there is a description of gaining a positive affect because he says he feels comforted and better. From the case description, the conclusion to make, then, is that this clearly describes a case of NSSH and not suicidal behaviour. Yet, if Parker picked at the sore when feeling upset, but he did not engage in the behaviour repetitively, but only once or twice, and he did not find the behaviour comforting, the conclusion to draw is still that this is an act of NSSH. The reason to conclude that this is not suicidal behaviour is that there is no expression of any intent to die, and the method used is not usually used in acts of suicidal behaviour.

Making clinical judgements with the four-question-analysis

To illustrate further how to use the four-question-analysis to distinguish NSSH from suicidal behaviour in clinical practice, consider the following hypothetical scenario drawn from a composite case. Imagine you are a clinician who is asked to see a young person called

Alison. Alison is 14 years old. Alison's parents have brought her to see you because they have discovered she is cutting herself. They discovered what she was doing when her mother became suspicious of the amount of time she was spending in the bathroom and walked in on her. To make a clinical judgment about whether Alison is engaged in NSSH you consider her answers to the four-question-analysis. Consider three possible sets of answers. In the first set of answers from Alison you are able to clearly make the clinical judgement that she is engaged in NSSH. In the second and third set of answers from Alison you are unable to clearly make a judgment.

Firstly, here is what Alison could say that would allow you to clearly make the clinical judgement that she is engaged in NSSH. Alison reports that she has been cutting herself most days for roughly six months. She reports using a blade from a pencil sharpener to cut herself. Alison tells you that she carries a purse with her that contains the blade, antiseptic wipes and plasters. She says she cuts herself privately in the toilets at school or in the bathroom at home. She reports finding relief in seeing the blood when she cuts. She says harming herself makes things feel real. She then reports that she takes time cleaning and dressing the cut. This helps her feel like she can make things better. As Alison is talking to you, she has expressed no desire to kill herself. Nevertheless, to be sure you ask Alison and she clearly says she does not want to kill herself. However, she does say that sometimes things feel very difficult, so she occasionally wonders what it would be like not to be alive, but these thoughts pass.

As a clinician, you consider Alison's answers to the four-question-analysis and clearly make the clinical judgement that Alison is engaged in NSSH. From her answers, there is no expression of intending to kill herself. She has expressed having passing thoughts about what it would be like if she was not alive, but these thoughts are not an expression of intending to kill herself. This means you are able to make the clinical judgement that her intention behind

the behaviour is not suicidal. The method, of cutting, indicates the behaviour is more likely to be NSSH rather than suicidal behaviour too. Considering only the intent behind the behaviour and method used makes it feasible to clearly make the clinical judgement that Alison is engaged in NSSH. In addition, Alison describes a repetitive nature to the behaviour and gains a positive affect from engaging in the behaviour, both of which suggest she is engaged in NSSH too.

On the other hand, here is a different set of answers that leave you unable to clearly make the clinical judgement that she is engaged in NSSH. Alison reports that she has been cutting herself most days for roughly six months. She reports using a blade from a pencil sharpener to cut herself. Alison tells you that she carries a purse with her that contains the blade, antiseptic wipes and plasters. She says she cuts herself privately in the toilets at school or in the bathroom at home. She reports finding relief in seeing the blood when she cuts. She says harming herself makes things feel real. She then reports that she takes time cleaning and dressing the cut. This helps her feel like she can make things better. As Alison is talking to you, she has expressed no desire to kill herself. Nevertheless, to be sure, you ask Alison whether she has a desire to kill herself and she does not answer the question.

As a clinician, you consider Alison's answers to the questions in the four-question-analysis. You are not clear whether the behaviour is NSSH. In this set of answers, the only difference is Alison's response to her intention behind the behaviour. All her other answers are the same and imply her behaviour is NSSH. She does not answer when asked directly about intending to kill herself. This makes you unsure about whether the behaviour is NSSH. You consider that maybe Alison is embarrassed about the question about killing herself and that is why she does not answer. She may be embarrassed about the question because she does have thoughts of killing herself. You wonder whether she may have thoughts about killing herself, but she does not cut herself to die. Due to the uncertainty around this key

question, you are not sure whether Alison is engaged in NSSH; however, you are leaning towards saying the behaviour is NSSH because of her answers to the other three questions. You continue to see Alison. After seeing her a few more times, she says that sometimes she wishes she accidentally cut deep enough to cut an artery. When you ask what Alison thinks would happen if she cut an artery, she says she would die. Now that Alison has told you she *sometimes* wishes she accidentally cut an artery that would result in her death, this makes it unclear to you when she is engaging in NSSH and when she is wishing she would kill herself, albeit accidentally.

Lastly, here is another set of Alison's answers that leaves you unable to clearly make the clinical judgement that she is engaged in NSSH. Alison reports that she has been cutting herself or taking large overdoses on most days for roughly six months. She has sometimes needed medical treatment after overdosing. She reports using a blade from a pencil sharpener to cut herself and taking large quantities of non-prescription painkillers. Alison tells you that she carries a purse with her that contains the tablets, blade, antiseptic wipes and plasters. She says she takes the tablets or cuts herself privately in the toilets at school or in the bathroom at home. She reports finding relief in seeing the blood when she cuts. She then reports that she takes time cleaning and dressing the cut. This helps her feel like she can make things better. She says harming herself by cutting and taking tablets makes things feel real. As Alison is talking to you, she has expressed no desire to kill herself. Nevertheless, to be sure of her intent you ask Alison and she clearly says she does not want to kill herself.

As a clinician, you consider Alison's answers. You are not clear whether the behaviour is NSSH. In this set of answers the only difference is Alison's response to questions about the method she uses. All her other answers are the same and suggest her behaviour is NSSH. However, taking large overdoses that require medical treatment is a method more likely used in suicidal behaviour. Also, even though cutting is more likely done

as a form of NSSH, some do try to kill themselves by cutting. Due to the uncertainty around this key question you are not sure whether Alison is engaged in NSSH. You are, particularly, not sure whether the act of taking large overdoses is NSSH as this is the method that is more likely to be suicidal behaviour.

There are some cases, then, that are unclear. However, I say that in practice it is not as difficult to distinguish NSSH from suicidal behaviour as Pickard claims. I suggest that it is feasible to clearly distinguish NSSH from suicidal behaviour in many cases by considering the intent and method, and, perhaps, the repetitive nature of the behaviour and psychological impact. To make this distinction a full clinical analysis should be carried out to ensure an informed judgement is made.

Another salient point to make is that Pickard does not suggest examining NSSH and suicidal behaviour as separate phenomena. Instead, she considers the two together, which is likely due to her claim about the difficulty of distinguishing them. By considering NSSH separately from suicidal behaviour, I have drawn attention to some important points – such as the function of characteristic cases of NSSH, and classifying NSSH according to the outcome or the intent – which would not be noticed if we did not distinguish NSSH from suicidal behaviour. I will say some more about the functions and discuss the characteristic features and the management of NSSH. I will also argue that NSSH in youth is never a mental disorder in its own right. I will continue to focus on NSSH because it is an important phenomenon in its own right that is able to be distinguished from suicidal behaviour.

Conclusion

Building on Pickard's work, I have pointed out the problems and limitations of two definitions from the World Health Organization and one from the NICE. I have come to a working definition of NSSH for use in this dissertation. The working definition is this: NSSH

is “the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned” (The ISSSI 2019b, para. 1). I have pointed to some of the further work that is needed to make the definition more precise. Furthermore, I say it is possible to clearly distinguish NSSH from suicidal behaviour in practice. By clinically assessing the behaviour with a four-question-analysis tool I suggest that it is possible to say when the behaviour is NSSH in many cases. During the discussions in this chapter, questions that require future research have been identified.

An additional area of research is the vague cases that some may deem to be examples of NSSH, such as the harming behaviour seen in Autism Spectrum, Lesch-Nyhan syndrome, Tourette syndrome and similar presentations. I shall briefly discuss the further research needed and why these cases do not fall within the phenomenon of NSSH discussed in this dissertation.

The working definition contains “deliberate”. The ISSSI (2019b, point 1) says “the harm that results from [NSSH] is an intentional or expected consequence of the behaviour. Risk behaviours that could result in harm, such as not wearing a seatbelt while driving, or accidental harm, that may occur when playing extreme sports, are typically excluded in our definition”. The ISSSI does not explicitly link this point to the inclusion of “deliberate”; however, due to the reference to an “intentional consequence” it is safe to assume that this is why the definition includes “deliberate”.

The inclusion of “deliberate” in the definition means that NSSH is a voluntary behaviour. The behaviour of harming oneself seen in people with Autism Spectrum, Lesch-Nyhan syndrome, Tourette syndrome and similar presentations poses an interesting question, then. The question is this: what is the function and level of physical involuntariness in the types of harming behaviour seen in these presentations? The types of harming behaviour

include biting fingers and lips, and head banging, which are observed alongside involuntary behaviours, such as vocal tics, flapping arms and jerking leg movements. These behaviours are commonly considered involuntary physical movements because they are neurological symptoms or responses of having Autism Spectrum, Lesch-Nyhan syndrome, Tourette syndrome and similar presentations.

All these cases in question do not qualify as instances of the characteristic cases of NSSH that I am investigating. The cases do not qualify because they do not have the same function as NSSH and because it is not clear that the behaviours are deliberate in nature. To illustrate this, consider two cases. In case A someone is using head banging as the form of NSSH I am discussing. In case B someone is engaged in head banging due to Autism Spectrum. Both cases A and B are causing self-inflicted damage to themselves and there is no suicidal intent connected to the behaviour. The two cases, perhaps, are engaging in head banging as a form of self-soothing. The person in case A who is engaged in NSSH is banging their head a few times. They are able to stop the behaviour themselves, and they say they bang their head to cope with overwhelming thoughts and feelings. Instead, the person living with Autism Spectrum in case B, perhaps, frequently bangs their head a dozen times a minute and does not stop until someone intervenes. They may repeatedly bang their head to distract themselves from other physical pain they are feeling in their body. Perhaps they involuntarily bang their head to provide a rhythmic physical rocking movement similar to the soothing sensation they felt being rocked in their parent's arms as a baby. Case B illustrates there are differences from the form of NSSH I am considering. The important point to note is that these cases that some may deem to be examples of NSSH, such as the harming behaviour seen in Autism Spectrum, Lesch-Nyhan syndrome, Tourette syndrome and similar presentations, do not fall within the phenomenon discussed in this dissertation.

Now that I have made this point I turn, in the next chapter, to the question: is NSSH in youth a mental disorder?

Chapter two: is non-suicidal self-harm in youth a mental disorder?[29]

The question

Imagine young people cutting themselves. The behaviour may have negative and sometimes dangerous consequences. Physical injury may include minor scratches, open wounds, infections, scars, nerve damage and accidental death. Negative psychological consequences may include reinforcing unwanted negative self-beliefs, and feelings of shame and guilt. Other negative consequences may include damage to relationships and to the person's ability to achieve her goals. Also, harming themselves may turn out to be a symptom of a mental disorder, or lead to a mental disorder or suicidal behaviour. They are cutting themselves when alone and when with their peers, but they are not doing it to commit suicide.[30] The behaviour, with the negative consequences, of cutting themselves appears destructive. Youth cutting themselves as a group seems abnormal. Youth causing themselves harm seems irrational. It is understandable that non-suicidal self-harm (hereafter referred to as "NSSH") in youth may be viewed as destructive, abnormal and irrational.

Arguments are presented in the literature for considering NSSH, across all ages, a distinct mental disorder (see Brausch 2019, 71-72 82-84, and Lengel and Mullins-Sweatt 2013, 940-941 for a summary). A proposal for a new disorder to be considered for inclusion in the '*Diagnostic and Statistical Manual*' (DSM) was submitted to the '*Childhood Disorder and Mood Disorder Work Groups*' of the American Psychiatric Association (Shaffer and

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[29] In parts of this chapter I use my philosophy journal paper titled '*Is non-suicidal self-harm in youth a mental disorder?*' (Ahir-Knight 2020).

[30] There are many people who engage in non-suicidal self-harm who are able to clearly say they are not intending to die or even think about killing themselves when they are engaged in non-suicidal self-harm (Kerr, Muehlenkamp and Turner 2010, 242).

Jacobson 2009 cited in Brausch 2019, 72). The American Psychiatric Association (2013) has said further research is needed, so it has included NSSH in the latest edition of the '*Diagnostic and Statistical Manual*' (DSM-5) in the '*Conditions for Further Study*' section (section III). The inclusion in this section of the DSM-5 means that further research is being encouraged on the proposed criteria for a "nonsuicidal self-injury" diagnosis (American Psychiatric Association 2013, section III '*Conditions for Further Study*'). Research will help inform whether to place this diagnosis in a future edition of the DSM.

The question of whether NSSH, across all ages, is a mental disorder requires serious consideration.[31] The question has practical importance, so it is currently being considered by researchers who are examining the proposed criteria for a diagnosis (see Brausch 2019, 73-82 for a summary). There are practical motivations for classifying NSSH, across all ages, as a mental disorder (as summarised by Brausch 2019, 82-84, and Lengel and Mullins-Sweatt 2013, 940-941). Here I present three compelling practical motivations.

Practical motivations

One practical motivation is to enable those who engage in NSSH to access specialist, secondary mental health treatment. The researchers Navneet Kapur, Jayne Cooper, Rory C O'Connor and Keith Hawton (2013) express their concerns about a "nonsuicidal self-injury" diagnosis.[32] Yet, the authors do point out that an NSSH diagnosis would mean that those who engage in NSSH would avoid an "inappropriate personality disorder" diagnosis, but instead have another formal diagnosis so they are able to access treatment (Kapur et al. 2013, 326). I

[31] An interesting question for future research is this: is the behaviour of NSSH in adults, who either start to engage in NSSH as an adult or started as a youth and continue long into adulthood, a mental disorder?

[32] Some of the researchers are also psychiatrists.

assume the researchers express this view because, from my clinical experience, most specialist, secondary mental health services in the United Kingdom, where these researchers are from, require someone to have a formal diagnosis before being offered treatment. Also, the researcher Amy Brausch (2019, 83) points out that "managed care systems are more and more likely to require a DSM diagnosis to reimburse for treatment, [so] including [NSSH] in the DSM would ensure coverage of [NSSH] treatment". This means that a practical motivation for an NSSH diagnosis is to enable those who engage in NSSH to access funded treatment.

Another practical motivation is to ensure that those who engage in NSSH are not misdiagnosed. The researchers Gregory J. Lengel and Stephanie N. Mullins-Sweatt (2013, 940) say that NSSH "has long been conceptualized as, and often limited to, a symptom that is pathognomonic to [borderline personality disorder]". Borderline personality disorder is characterised by "A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity" (American Psychiatric Association 2013, section II '*Personality Disorders*'). Historically, those who engaged in NSSH have been misdiagnosed as having a borderline personality disorder (see Brausch 2019, 71-72 and 82 for a summary of this point). Kapur and colleagues (2013, 326) refer to this point too when they say an NSSH diagnosis would avoid an "inappropriate personality disorder" diagnosis. Brausch (2019, 72) says that researchers and clinicians have been voicing concerns that borderline personality disorder is not an appropriate diagnosis for all those who engage in NSSH. This means that a practical motivation for an NSSH diagnosis is to enable those who engage in NSSH to receive this diagnosis rather than be misdiagnosed with, particularly, borderline personality disorder.

Also, a further practical motivation to have an NSSH diagnosis is to enable researchers to have a clear definition to allow them to do more focused research. Brausch

(2019, 83) says once diagnostic criteria for NSSH are established the research is "likely to flourish" because "the criteria will provide a standard and consistent definition of [NSSH] that researchers can embrace, helping to unite research on this disorder". She says that having a diagnosis for NSSH would encourage research to improve the understanding of NSSH and fill the serious need for research into the development of effective treatment for NSSH (Brausch 2019, 83). Hence, there are practical motivations for having an NSSH diagnosis available.

My claim

Despite these practical motivations, in this chapter, I argue that NSSH in youth is never a mental disorder in its own right. What I consider to be "NSSH" has been outlined in detail in chapter one. It is NSSH, as seen in these types of cases, that I claim is not, in its own right, a mental disorder in youth. I consider "youth" to be those aged from 10 to less than 25 years old.

My strategy

In this chapter, I offer an argument by comparison. I identify the characteristic features and functions of NSSH in youth and, by describing how these features and functions are also seen in non-disordered behaviours in youth, I demonstrate that NSSH in youth, in its own right, is non-disordered too.

My argument that non-suicidal self-harm in youth is not a mental disorder

I am of the view that NSSH in youth is never a mental disorder in its own right. Instead, I argue that NSSH is a characteristic behaviour in youth that when seen in youth has

an understandable practical function. To make my argument, I compare other characteristic behaviours seen in youth with NSSH. First, I discuss characteristic behaviours in youth. Then I explore the practical function of NSSH in youth and show that it is understandable.

Characteristic behaviours in youth

Youth engage in characteristic behaviours that are part of passing phases in life. These "characteristic youth behaviours" include behaviours that may commonly be considered, perhaps, risky, harmful, destructive, irrational and reckless. For instance, youth may dive from high bridges into rivers, do skateboarding tricks without any protective clothing, go travelling to remote areas alone, or risk arrest and even their lives by organising activist movements. Also, youth may experiment with illegal drugs, stay out late, have unprotected sex, or take risks while driving, such as speeding or driving when under the influence of alcohol or drugs. These kinds of behaviours are what I refer to as "characteristic youth behaviours". They are "characteristic *youth* behaviours" because they are more likely to be seen in youth than in people at other stages of life.

I use the term "characteristic youth behaviours" to refer to behaviours that present temporarily, as part of a passing phase, and produce goods of adolescence. I am not suggesting that it is necessary for every youth to engage in these behaviours to have a good human life; however, there are reasons to think that engaging in these behaviours is good for some people during adolescence.

Characteristic youth behaviours are instrumentally valuable because these behaviours help with development. When a young person is developing her identity, she may need to experiment with many ways of being to discover who she is.[33] To be able to try different

[33] Erik Erikson's (1959) theory of psychosocial development says that adolescence is one in a sequence of development stages that span an individual's life. According to Erikson (1968),

ways of being she needs to take risks. The risks she needs to take may include risks of physical harm, such as when she experiments with illegal drugs or does skateboarding tricks without any protective clothing, but they may not necessarily involve risk of physical harm: she might risk failing or being teased. For example, she may risk being teased for experimenting with different clothing styles or she may risk failing when she auditions for the school choir. She must, then, be willing to try things that carry risk. Through characteristic youth behaviours, she may also develop her independence. She may understand what the negative consequences of her actions are from being told by others, but she still engages in the behaviour.[34] Also, she may be more willing to accept situations when the outcome is uncertain so experiencing the negative consequences herself helps her to learn from her mistakes.[35]

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adolescence is described as a stage that involves the individual being free to experiment and explore different identities.

[34] Researchers suggest that adolescents are aware of the costs of engaging in behaviours that carry risk and that providing adolescents with information about the risks only occasionally changes their behaviour (see Steinberg 2007, 55 for a discussion). Adolescents have the ability to reason, but it is suggested that they are still developing capacities that improve making decisions, such as impulse control and emotional regulation, and this is why they engage in these behaviours (Steinberg 2007, 56-58).

[35] It is suggested that adolescents also take more risks because they have a higher level of tolerance for the unknown (Tymula et al. 2012). On this view, researchers have said that providing safe environments for adolescents to experience and learn about risky situations may be an effective strategy to prevent harm, such as adolescents using a simulator to experience what it is like to drive while intoxicated (Tymula et al. 2012, 17139).

Characteristic youth behaviours are instrumentally valuable during this stage of life too. During adolescence, thoughts, emotions and behaviours may be more intense. For example, the desire to be accepted and fit in with a peer group is more intense. This intense desire to fit in may mean a young person does things they would not otherwise do. Another example is of youth who have intense thrill-seeking desires during this stage of their life, which characteristic youth behaviours satisfy. To put it another way, characteristic youth behaviours satisfy the desire for youth to "set the world on fire".[36]

Also, during this stage of one's life, youth are likely to be less accountable to others, so they are able to engage in behaviours that may be considered fun and reckless despite the negative consequences.[37] For example, a young person may enjoy binge drinking and not be concerned with the negative consequences of the behaviour. The negative consequences may include having a hangover the following day, which does not concern them because they are able to occasionally skip class and stay in bed. The young person does risk failing their subject if they often miss class, but they may not be concerned by this consequence because, for example, they have the ability to repeat the class, failing the class does not have an overall

[36] This is a line from a song titled '*We are Young*' written by Jeff Bhasker, Andrew Dost, Jack Antonoff and Nate Ruess and performed by the band '*Fun*' featuring the singer Janelle Monáe.

[37] It is not always the case that a youth has less accountability to others than an adult. For example, a youth may have carer responsibilities or have to work to support themselves. However, the romantic view of being a young person is of a care-free life that is not burdened with responsibility. In contrast, an adult's life usually involves responsibilities, such as to their children and their elderly parents, and saving for their grandchildren's future.

impact on their course or they do not see failing the class as a negative consequence. This means for them there are few disadvantages to binge drinking.

In contrast, the stakes are likely to be higher for an adult because they risk wider negative consequences. For example, an adult may enjoy binge drinking but doing so means they are not able to legally drive the following morning. This results in someone else having to drive their child to school. Also, having a hangover the following day may result in them not being able to concentrate at work, which impacts on how their colleagues and manager view them. The negative consequences, then, for the adult include burdening others to drive their child to school, being frowned upon for not being available for their child and getting into trouble at work. This means for them there are more disadvantages to binge drinking.

Children and adults engage in characteristic youth behaviours too. For example, a child may dive from bridges into rivers and an adult may drive when under the influence of drugs or alcohol; however, it is unusual for a child or adult to engage in many of these types of behaviours and at an extreme level as youth do. A child or adult regularly engaging in risky, harmful, destructive, irrational and reckless behaviour would be odd. Also, while adults recognise that characteristic youth behaviours need to be managed in youth due to the harmful and negative consequences, they are likely to recognise that engaging in risky, harmful, destructive, irrational and reckless behaviour is a characteristic part of development and being a youth.

The function of non-suicidal self-harm in youth

Although characteristic youth behaviours may be risky, harmful, destructive, irrational and reckless, they are also sometimes useful. For instance, a young person may want to fit in with a group, so she starts smoking tobacco, even though it causes her harm. Similarly, another young person is developing independence, so she challenges her family's values and experiments with illegal drugs, even though it causes her harm. All these types of

characteristic youth behaviours have an understandable motivation behind them and, while harmful, have an understandable practical function during adolescence.

NSSH in youth also has an understandable practical function during adolescence. The main function of NSSH in youth is to serve as a mechanism for coping with intense emotions and thoughts by providing temporary relief to enable the person to manage life (Hasking et al. 2016, 646, Lewis and Heath 2015, 527, and Moran et al. 2012, 241). From my clinical experience and the literature, other functions of NSSH in youth include to experience a feeling when one is feeling emotionally empty, to feel a sense of connection with oneself, to stop suicidal thoughts and urges, to punish oneself, to communicate one's distress to others (particularly when other means of trying to communicate distress have not been effective), to feel in control, to try out a new behaviour, and to fit in with other peers who engage in NSSH (Hasking et al. 2016, 646-645, Klonsky and Glenn 2009, 215-219, and Lewis and Heath 2015, 527). While NSSH is harmful, there is often an understandable motivation behind someone's decisions to engage in this behaviour.

The first-person narrative from Mike Ehrmantrout's online blog illustrates the understandable practical function of NSSH. He shares his story of getting his thumb caught in the boot of a vehicle when he was a boy:

> As I began to heal, I noticed the skin on my thumb became quite coarse. I still don't quite understand, but for some reason, the coarse skin felt comforting to me, even soothing.
>
> Instead of letting the wound heal, I began to pick at the skin in order to feel the comforting feeling. I found that I could make the skin even rougher by picking at it with a safety pin.
>
> No one realized at the time that I was engaging in self-harming behavior. I had been through much trauma in my earlier childhood, and somehow, this made me feel better.

> This went on for a few years until I just kind of grew out of it, but the scar remains (Ehrmantrout 2014, paras. 4–7).

For Ehrmantrout, the function of NSSH is described as helping him feel better.

From my clinical experience and the literature, there are different factors that may collectively contribute to a young person engaging in NSSH (Lewis and Heath 2015, 527 Moran et al. 2012, 241, and Robinson et al. 2018, 328). Factors potentially associated with NSSH in youth include a low serotonin level, a separate diagnosable mental disorder, bullying, abuse, neglect, low self-esteem, getting into trouble with the police, over-controlling parenting, a poor attachment to one's parent, being unable to problem-solve, a poor ability to regulate their emotions, worries about sexual orientation, certain temperaments and perfectionism. Triggers for NSSH in youth sometimes are problems such as falling out with friends, under-performing in an exam and breaking up with a boyfriend or girlfriend.

The characteristic features of non-suicidal self-harm in youth

First, before showing how characteristic youth behaviours are analogous to NSSH, it is helpful to summarise the characteristic features of NSSH in youth. The empirical literature agrees that NSSH is a behaviour that is prevalent amongst youth (Lewis and Heath 2015, 526, Muehlenkamp et al. 2012, 1 and 6, and Zetterqvist et al. 2013, 759-760 and 768). There is literature that shows youth will often engage in NSSH more than once and many will regularly engage in NSSH (Hasking et al. 2016, 646, Moran et al. 2012, 239-240, and Zetterqvist et al. 2013, 765). The literature says that NSSH in youth sometimes occurs alongside a separate diagnosable mental disorder such as depression, anxiety, post-traumatic stress disorder and (with older youth) personality disorders (Hasking et al. 2016, 645, Lewis

and Heath 2015, 527, and Moran et al. 2012, 241);[38] however, it must be noted that the literature says as well that sometimes NSSH in youth does *not* occur alongside a separate diagnosable mental disorder (Hasking et al. 2016, 645, and Lewis and Heath 2015, 526-527).[39]

Also, there is research that shows that as most young people who engage in NSSH mature, they stop (Moran et al. 2012, 238 and 241-242). This research is a longitudinal study that examined the incidence of collectively NSSH and suicidal behaviour from adolescence to young adulthood. A random sample of 1,943 school pupils aged 14-15 years old was recruited from different schools to take part in the research study, which involved follow-ups as they grew older (Moran et al. 2012, 236-237). The last stage of follow-up was when they were aged 28-29 years old. The participants were asked about engaging in NSSH and suicidal behaviour at different stages. Those who reported engaging in NSSH and suicidal behaviour reported using methods such as cutting, burning, poisoning and suffocation (Moran et al. 2012, 237). The commonest method reported during adolescence was cutting and burning (Moran et al. 2012, 241). Of all the participants who took part in both the adolescent and young adult stage of the study, less than 1 per cent reported engaging in harming behaviour as an adolescent and as an adult (Moran et al. 2012, 238 and 240). The researchers reported

[38] A personality disorder diagnosis is generally not given to those under the age of 18 years old because "their personalities are still developing" (American Psychiatric Association 2018, under the '*Types of Personality Disorders*' heading).

[39] I use the phrase "occurs alongside a separate diagnosable mental disorder" rather than "a symptom of a disorder". The reason I use "occurs alongside" is because it is not necessary for me to make a claim about whether a behaviour is a symptom of a separate diagnosable mental disorder. My claim is that NSSH in youth is never a mental disorder in its own right.

that symptoms of depression and anxiety during adolescence were clearly associated with harming behaviours in young adulthood (Moran et al. 2012, 241).

Lastly, NSSH is a risk factor for suicidal behaviour (Franklin et al. 2017). A "risk factor" for suicidal behaviour is something that precedes suicidal behaviour and "can be used to divide the population into high- and low-risk groups" (Franklin et al. 2017, 190). For example, if those with anxiety were more likely than others to engage in suicidal behaviour now or in the future, anxiety would be a risk factor for suicidal behaviour.

Philosophers have already pointed out that NSSH is a risk factor for suicidal behaviour. Eccy de Jonge (2005, 31) states that the pain that causes someone to engage in NSSH "may well increase and lead from [NSSH] to suicide". Also, Hanna Pickard points out the increased risk of suicide amongst those who engage in NSSH. She says "Indeed, self-harming behaviour is associated with a 50–100-fold increase in risk of suicide compared to the general population" (Pickard 2015, 75).[40] She takes this finding from the United Kingdom National Institute for Health and Clinical Excellence (hereafter referred to as "NICE") long-term management guidelines of NSSH and suicidal behaviour (NICE 2011).[41] The guidelines provide the United Kingdom (UK) health services with long-term psychological recommendations for managing NSSH and suicidal behaviour in those aged 8-years and older.

However, for some people, NSSH is used to prevent suicidal behaviour (Hasking et al. 2016, 646, The ISSSI 2019b, point 3, and Lewis and Heath 2015, 527). To illustrate this,

[40] According to a more recent meta-analysis study the risk may not be this high (Franklin et al. 2017, 210). However, the point I make will stand even at the higher level.

[41] The United Kingdom National Institute for Health and Care Excellence used to be named the "National Institute for Clinical Excellence". For ease I use "NICE" to refer to both.

the NICE long-term management guidelines to which Pickard refers follow the NICE short-term management of NSSH and suicidal behaviour guidelines. The short-term guidelines provide recommendations to UK health services about the short-term physical and psychological management of NSSH and suicidal behaviour in those aged 8-years and older. The NICE short-term guidelines (2004, 18) point out that "Paradoxically, the purpose of some acts of self-harm is to preserve life". This suggests that in some cases, NSSH is being used by an individual to stop him from trying to kill himself. I have not been able to locate research that shows how many people use NSSH to stop themselves from trying to kill themselves or how effective the method is.

To illustrate how NSSH may stop someone from killing themselves consider the first-person narrative of Andrew Lawes (2012, paras. 16–17), which I presented in the first chapter:

> that was the first night in weeks I didn't want to die. Because, no matter what depression did to me, I could control the bleeding. When I cut, it helped to take away thoughts of suicide.
>
> My body is adorned with the scars of self-harm. But they aren't scars of suicide attempts. They aren't scars of wanting to die. They are scars of wanting to feel alive, and feel in control of the life I had. If I hadn't self-harmed, I might not be here today. But I did, and I am.

This means when considering a particular individual NSSH may be stopping him from trying to kill himself. However, as population-level research shows, NSSH is a risk factor for suicidal behaviour. Hence, the final characteristic feature of NSSH in youth is that NSSH, at a population level, is a risk factor for suicide.

To summarise, the six characteristic features of NSSH in youth are:

(1) it causes harm

(2) it is prevalent in youth

(3) it is often a repeated behaviour

(4) it occurs, for most, only in the youth years and stops when the person matures

(5) it sometimes occurs when someone has a separate diagnosable mental disorder, like depression or anxiety, but sometimes it occurs in those who have no separate diagnosable mental disorder

(6) it is a risk factor for suicide.

By now describing how these features are seen in other, non-disordered, characteristic youth behaviours, I will argue that NSSH in youth, in its own right, is a non-disordered behaviour too.

Some characteristic youth behaviours are analogous to non-suicidal self-harm in youth

First, I will compare binge drinking with NSSH in youth. The characteristic youth behaviour of binge drinking shares all six features of NSSH in youth. "Binge drinking" is drinking to become drunk or drinking a large volume of alcohol over a short period of time. Firstly, (characteristic feature number 1) it causes harm. The harmful and negative consequences of binge drinking may include being physically unwell, living with the embarrassment of what you did while under the influence and getting into trouble with your parents. Binge drinking may also cause significant harm, such as getting into fights, damaging relationships, long-term physical and mental health problems, and death. Next, (characteristic feature number 2) it is prevalent in youth (Carter, Filoche and McKenzie 2017, 10-12). Imagine music festivals, house parties and university fresher weeks where youth will regularly drink heavily (characteristic feature number 3) and, then, for some, as they mature

(characteristic feature number 4) they either try to stop drinking or consume lower amounts of alcohol (Carter, Filoche and McKenzie 2017, 23).[42] [43]

The characteristic youth behaviour of binge drinking shares similar understandable practical functions during adolescence with NSSH in youth. Parents will tell their children about the dangers of binge drinking only for their child to continue. This is partly because youth find binge drinking useful. Youth use alcohol for a variety of different reasons (Carter, Filoche and McKenzie 2017, 15-16). Some youth may binge drink to cope with intense emotions, such as feeling anxious, to drown their sorrows after breaking up with their girlfriend or boyfriend, or to fit in with other peers who drink. These functions are the same for NSSH in youth. While binge drinking is harmful, there is often an understandable motivation behind someone's decisions to engage in this behaviour.

To illustrate the functions of binge drinking, consider the hypothetical case of Julia, a young person who is shy and reserved. She wants to feel a sense of belonging with her peers, so being invited to a party brings that sense of belonging, but also anxiety. At the party, she starts to drink. She is still feeling anxious, so she drinks more and more. Julia binge drinks.

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[42] Carter and colleagues (2017, 23) say "young people living in areas of high deprivation were twice as likely to have stopped drinking or tried to cut down". The authors are cautious about this being a positive point because it is not clear whether those who attempt to stop or drink less are successful in the long-term.

[43] Feature four is that NSSH in youth occurs, for *most*, only in the youth years and stops when the person matures. However, I say that only *some* young people stop drinking or consume lower amounts of alcohol as they mature. The difference I assume is due to several factors including the promotion of alcohol.

Others comment on how funny she is when she is drunk. Binge drinking serves an understandable practical function as a youth. Binge drinking has allowed her to feel confident and cope at the party. This has resulted in her feeling liked and accepted. This means, even though she has to deal with the harmful and negative consequences of being told off by her parents and being unwell, she binge drinks again the following weekend at the next party. As she matures and develops new skills, binge drinking no longer serves this function, so she reduces the amounts she drinks.

I will now discuss the final two features. These features are that binge drinking (characteristic feature number 5) sometimes occurs when someone has a separate diagnosable mental disorder, like depression or anxiety, but sometimes it occurs in those who have no separate diagnosable mental disorder, and that binge drinking (characteristic feature number 6) is a risk factor for suicide (Carter, Filoche and McKenzie 2017, 22). To illustrate this, consider the composite case of Daniel, a 15-year-old male. He had been diagnosed with an anxiety disorder and was receiving specialist, secondary mental health treatment in his home. As treatment progressed, he started spending time with his friends again. Outside of school, his friends would spend time at the skate park or playing computer games. Due to his anxiety, Daniel did not want to go to the skate park, so at the weekends he would go to a friend's house to play on the computer. This also involved binge drinking. This was the only time Daniel felt able to see his friends, so he would binge drink with them to feel connected to them. The anxiety disorder was viewed as possibly contributing to the behaviour of binge drinking and his alcohol consumption was monitored. As treatment progressed, Daniel stopped feeling anxious. He returned to school and he felt easier about socialising with his friends. He no longer had an anxiety disorder; however, he continued to engage in the characteristic youth behaviour of binge drinking.

One of the reasons why Daniel's alcohol consumption was monitored by the mental health team was that binge drinking may lead to mental disorders, such as depression and alcohol dependence. Both depression and alcohol dependence are risk factors for suicide. As Daniel had an anxiety disorder, he was already vulnerable to developing other disorders, so binge drinking made him even more vulnerable, so was viewed, by the mental health team, as having a further vulnerability in addition to his anxiety disorder. Yet, his binge drinking was assessed as a characteristic youth behaviour.

To further illustrate my point, that characteristic youth behaviours are analogous to NSSH in youth, I now briefly discuss another example. The characteristic youth behaviour of smoking tobacco shares all six features of NSSH in youth. Firstly, (characteristic feature number 1) smoking tobacco causes harm to oneself. Harm may include physical health concerns and a financial drain. The harm to one's physical health, caused by smoking tobacco, is well known due to health campaigns. The harm includes damage that may be seen, such as dull skin and stained teeth. The harm also includes what may not be explicitly seen, such as damage to the heart and lungs. Many health campaigns around the world use images of internal harm, caused by smoking tobacco, to act as a visual reminder of the physical harm people are doing to themselves, with the aim of deterring them from smoking tobacco.

The characteristic youth behaviour of smoking tobacco shares similar understandable practical functions during adolescence with NSSH. Parents will tell their children about the dangers of smoking tobacco only for their child to continue. This is partly because youth find smoking tobacco useful. Youth smoke tobacco for a variety of different reasons (U.S. Department of Health and Human Services 2012, chapter 2). For example, youth may smoke tobacco to cope with intense emotions and thoughts, or to try out a new behaviour. These functions during adolescence are the same for NSSH in youth. Thus, while smoking tobacco

is harmful, there is often an understandable motivation behind someone's decisions to engage in this behaviour.

Secondly and thirdly, (characteristic feature number 2) while the number that smoke tobacco may be declining, (characteristic feature number 3) regular smoking is still relatively significant amongst youth (U.S. Department of Health and Human Services 2012, 135-157). Fourthly, (characteristic feature number 4) while many youth continue smoking tobacco into adulthood, many will also smoke as youth and then try to stop (U.S. Department of Health and Human Services 2012, 191). Fifthly, (characteristic feature number 5) smoking tobacco sometimes occurs alongside a mental disorder (Bronisch, Höfler and Lieb 2008, 136, and U.S. Department of Health and Human Services 2012, 27-28). Lastly, (characteristic feature number 6) smoking tobacco is a risk factor for suicide. Further empirical research is required, as with other behaviours, to establish how strong a risk factor it may be. However, there is research to support the final characteristic feature of NSSH in youth — that smoking tobacco is a risk factor for suicide (Bronisch, Höfler and Lieb 2008, 136 and 141-143, and U.S. Department of Health and Human Services 2012, 195).

To conclude my argument

I have argued that commonly seen, non-disordered, characteristic youth behaviours, such as binge drinking and smoking tobacco, are similar in all relevant respects to NSSH in youth. These common phenomena are not mental disorders, in their own right, so there is a good reason to conclude that NSSH in youth is never a mental disorder in its own right, either.

Making progress when there is disagreement

My argument has significance for the general discussion about mental disorders too. One way to argue that a phenomenon, such as NSSH in youth, is not a mental disorder is to present a definition of mental disorder and then argue that the phenomenon does not fit the definition. The difficulty with this approach is that there is no widely accepted definition of mental disorder; there is a significant body of literature on the differing definitions and problematic cases (see Cooper 2013 for a summary of some of the views). What I offer then to the discussion is my strategy of argument by comparison to determine whether a phenomenon is a mental disorder, while not taking a stance on the definition of mental disorder. This means progress can be made even when there is disagreement about what mental disorder is and vagueness about how to apply a definition.

Yet, someone may want to argue that NSSH in youth is never a mental disorder in its own right by presenting a definition of mental disorder and then arguing that the phenomenon does not fit the definition.

Argument by definition

If someone wanted to use the argument by definition strategy the first task would be to settle on a definition of mental disorder. There are many existing definitions of mental disorder to choose from. For example, one definition is that mental disorders are natural statistical dysfunctions (Boorse 1976). A further definition is that mental disorders are mental functions that limit someone's ability to live a good life (Megone 1998 and 2000). To illustrate this argument strategy then consider another well-known definition.

The chosen definition of mental disorder is from the multidisciplinary academic with clinical experience Jerome C. Wakefield. Wakefield's (1992, 374) definition is that a mental disorder is a "harmful dysfunction".[44] He says:

[44] The definition applies to physical disorder too (Wakefield 1992, 374).

> wherein *dysfunction* is a scientific and factual term based in evolutionary biology that refers to the failure of an internal mechanism to perform a natural function for which it was designed, and *harmful* is a value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards (Wakefield 1992, 374).

To put it another way, a mental disorder must be an evolutionary natural dysfunction and harmful.

The second task for someone using the argument by definition strategy is to apply the definition to NSSH. This involves determining what internal mechanism causes NSSH and then trying to find the evolutionary natural function of this internal mechanism to work out whether there is a dysfunction. Furthermore, this involves working out what is considered "harmful" by sociocultural standards and whether this concept of harm applies to NSSH. This is a perfectly good strategy to take if someone is able to address the big conceptual questions, such as what harm and dysfunction are in the case of NSSH. However, the argument by definition strategy is not the only approach. What I offer, then, to the discussion about mental disorders is another option to determine whether a phenomenon is a mental disorder.

The "institutional definition" of disorder

Of course, someone may want to use the argument by definition strategy, by borrowing from the wider literature on the definition of health and disorder, to say that NSSH in youth is a mental disorder in its own right. The philosopher Quill Rebecca Kukla (writing as Rebecca Kukla 2014) offers an "institutional definition" of disorder.[45] To explain Kukla's definition of disorder I need to spend some time describing what they say.

[45] In chapter five (pp. 132-144) I come back to Kukla's work (2014).

Firstly, Kukla (2014, 525-527) understands health as an "institutional concept". They offer the following definition:

> *The Institutional Definition of Health*: A condition or state counts as a health condition if and only if, given our resources and situation, it *would be best for our collective well-being* if it were medicalized—that is, if health professionals and institutions played a substantial role in understanding, identifying, managing and/or mitigating it. In turn, *health* is a relative absence of health conditions (and concomitantly a relative lack of dependence upon the institutions of medicine) (Kukla 2014, 526).

This means that if health institutions should be involved in the assessment or management of a phenomenon then that phenomenon should be considered a "health condition".[46]

"Health conditions"

Before I say how Kukla's definition may imply that NSSH in youth is a mental disorder in its own right, I need to spend some time on the details of what Kukla says about the "health conditions" part of their definition. Kukla (2014, 526) says:

> The essential idea here is that *real* health conditions are conditions for which the tools and methods and support of medicine and its institutional mechanisms are genuinely helpful, given both the natural and social facts. This is something we can be *wrong*

[46] Kukla's definition is similar to the "social constructionist definition", which will be discussed in chapter five (pp. 141-145). Both definitions include medicalisation by health institutions (Kukla 2014, 526). However, Kukla (2014, 526) says that their institutional definition differs because it "talks about what we *should* medicalize, from the point of view of our collective flourishing, rather than what we *do* medicalize".

about and can *empirically discover.* That something is a health condition is a social fact, which is dependent on what medicine has to offer and the social context of the condition, but not a *purely* social fact.

Kukla (2014, 526) also says "The institutional definition of health is a realist one, in the sense that one can *discover* that something is properly thought of as a health condition, by *learning* that the toolkit of medicine is helpful". This means that when clinical tools, such as assessment and intervention tools, are helpful to use in the management of a phenomenon then that phenomenon is a "health condition".

Kukla (2014, 526) goes on to point out that the institutional definition does *not* lead to two consequences. They first say:

> It is *not* a consequence of my account that all health conditions deserve medical treatment, or even that medical treatment is always the best option. Something might meet my definition of a health condition because it is best *diagnosed and classified* using the tools of medicine, but then best managed using non-medical strategies. Mild hypertension might be a candidate, for instance. Perhaps it is best, all things considered, for us to use medical tools to identify and label mild hypertension, but also best all-in to address it with lifestyle changes and self-monitoring (as opposed to pharmaceuticals, say) (Kukla 2014, 526).

Secondly, Kukla (2014, 526) says:

> It is also not a consequence of my account that an *individual* counts as having a health condition just because providing medical services to that *individual* would benefit her or him. I've defined health in terms of our *collective* well-being. So for example, just because an individual might personally benefit from cosmetic breast augmentation, this does not mean having smallish breasts is properly categorized as a health

condition. The question would be whether using the tools of medicine to manage small-breastedness would be better for our collective well-being, and this is much less plausible than that particular individuals might benefit.

Kukla (2014, 527) also says:

I suspect that for normative purposes, carefully separating diseases from other health conditions will not turn out to be very important (in contrast to its importance within a scientistic account of health). Roughly, we can think of a disease as a repeatable, relatively stable bodily state or process that systematically causally contributes to one or more health condition. Notice that, on this definition, particular diseases may be natural kinds, definable and identifiable apart from human practices (in terms of their viral or genetic underpinning, say). But *that* a condition is a disease is an institutional fact, not a purely natural fact, as this depends on its relationship to health conditions, which are institutional concepts. And the concept of disease itself is likewise, here, an institutional concept.[47]

From Kukla's explanation I am not clear how a "health condition" is different from a disorder. Clearly their definition implicates that a "health condition" is a disorder, whether that be an "institutional concept" or a natural kind.

In their work, their test case implies that health conditions are disorders. Kukla (2014, 528-529) uses the case of gender dysphoria (also referred to as gender identity disorder) to show how their definition works. As they say gender dysphoria "is the official diagnostic

[47] The "scientistic definition", which will be discussed in chapter five (pp. 134-141), focuses on what the natural sciences tell us about the nature of disorder.

category for transgender people; it marks out transgender as a unified *health condition*" (Kukla 2014, 528). They say:

> Whether gender dysphoria is a "real" health condition, on my account, is not a question of whether it corresponds to some substantial biological dysfunction (as on a scientistic account), nor is it simply answered by noting that we treat it as one (as on a social constructionist account). Rather, the question of the "reality" of the diagnostic category is a question about whether we *should* use the tools and techniques of medicine for addressing the needs of trans folks (Kukla, 2014 528).[48]

They go on to say that:

> gender dysphoria is a legitimate medical diagnosis just insofar as bringing it under the purview of medical institutions enhances human flourishing and the ends of justice. I hypothesize (though I certainly cannot thoroughly prove here) that, as *a matter of contingent*, *historical fact*, it has turned that the diagnostic category of gender dysphoria, and the medical tools and procedures that it gives access to, have increased the well-being of trans folks (and indeed people in general), all things considered . . . Thus, on my account, gender dysphoria counts as a legitimate, bona fide *health condition*—a condition that is in the running for various rights to access to health services in a just state (Kukla 2014, 529).

This leaves me with the impression that Kukla's "health condition" is a certain kind of disorder and that Kukla's definition is an institutional definition of disorder.

[48] Kukla (2014, 530) includes a footnote about the term "trans" saying that the term "can include those who identify as transgender, transsexual, transvestite, or other variation, without the need for us to lock down these possibilities in advance".

The view: "non-suicidal self-harm in youth is a mental disorder in its own right"

I claim that NSSH in youth is never a mental disorder in its own right. However, Kukla's definition may imply that NSSH in youth is a disorder. To explain let me remind us of some relevant points. Kukla (2014, 526) says "A condition or state counts as a *health condition*" (hereafter referred to by me as a "disorder") when clinicians should play "a substantial role in understanding, identifying, managing and/or mitigating it" because "it *would be best for our collective-wellbeing*". Also, they say that it is not a consequence of their definition "that an *individual* counts as having a [disorder] just because providing medical services to that *individual* would benefit her or him" (Kukla 2014, 526). For Kukla (2104, 526) what matters is it being beneficial for "*collective well-being*". This means even if a young person who is engaged in NSSH would benefit from an intervention that targets the harming behaviour it does not follow that the young person's NSSH is a disorder. However, if using "the tools of medicine" to manage NSSH is beneficial for our "*collective well-being*", then NSSH would be a disorder (Kukla 2014, 526). This means that on Kukla's view if collective well-being is improved by giving young people who engage in NSSH access to clinical assessment and intervention tools then NSSH is a disorder.

Access to clinical tools

First, I discuss the need for youth who engage in NSSH to have access to clinical assessment tools. In chapter one (pp. 29-36), I used the work of Patrick L. Kerr, Jennifer J. Muehlenkamp and James M. Turner (2010) to show how to distinguish NSSH from suicidal behaviour. I said that by considering the intent behind a behaviour, the method used, whether the behaviour is repetitive and the psychological impact of the behaviour, it is feasible to differentiate suicidal behaviour from NSSH in many cases. I referred to this as a "four-question-analysis". This is a clinical assessment tool that when used will determine whether

someone is engaged in NSSH or suicidal behaviour. It is practically beneficial to clearly determine what something is before asking whether clinical interventions would be helpful. With the hypothetical scenario drawn from the composite case of Alison, in chapter one, I showed that a full clinical analysis should be carried out to ensure an informed judgement is made.

Secondly, I discuss the need for some youth who engage in NSSH to have access to intervention tools. Consider the composite case of Parker again from chapter one. Parker has been engaging in NSSH with the method of picking at a sore with his fingernails and a safety pin. Imagine that he is engaging in the behaviour in the classroom in front of others, exposing the sore for others to see and encouraging his peers to engage in a similar behaviour. In this case, due to the impact on others, there may be a need for an intervention to stop the harming behaviour or to stop him from encouraging others. Also, imagine that Parker has been engaging in the behaviour now for years and the sore becomes regularly infected. In this situation Parker may need an intervention that helps prevent the risk of infections or to tackle why he continues with the behaviour. Lastly, imagine Parker is concerned about his behaviour. He has become troubled about how the sore looks and what other people think about his behaviour. He desires to stop engaging in NSSH, but he is struggling to cope with events in his life without causing harm to himself. In this case, Parker warrants an intervention to help him develop other strategies to cope.

Hence, using a clinical tool is best for assessing NSSH and in some cases youth who engage in NSSH should be given access to intervention tools. On Kukla's view the question to ask then is whether using these assessment and intervention tools to manage NSSH is beneficial for our collective well-being. If the answer is yes, then NSSH is a disorder.

Being beneficial for our collective well-being

First, I offer some ideas on how using clinical tools to manage NSSH in youth may be beneficial for those who have a relationship with youth who are harming themselves. Using clinical tools to manage NSSH in youth may reduce the potential for the contagion effect of NSSH.[49] Also using the tools to stop the harming behaviour may stop the distress others experience. Additionally, in some cases, the harming behaviour takes away the attention that is needed for others. For example, in the case of Parker engaging in NSSH in the classroom, the harming behaviour takes away the teacher's attention from teaching. This is because the teacher has to deal with the harming incident. Using clinical tools to manage this situation may, then, improve the well-being of the teacher and the other pupils.

Secondly, some may have the view that using the clinical tool of diagnosis produces an improvement in the well-being of the youth who is engaged in NSSH. Someone with this view may draw upon the work of the philosopher Nomy Arpaly (2005) who, does not discuss NSSH but, points out that being given a diagnosis makes one's mental struggles appear legitimate to oneself and others. She says:

> A person confessing to severe mood swings may be reassured that 'we all feel this way', and fail miserably in her struggle to explain that mood swings are not the same

[49] The term "NSSH contagion" is used in the clinical literature and in practice (see, for example, Hasking et al. 2016, 654-656). The researchers Walsh and Rosen (1985 cited in Hasking et al. 2016, 654) have defined the contagion of NSSH in two ways: (1) when two or more people within the same group engage in NSSH within 24 hours, and (2) when there are statistically significant clusters of NSSH within a group. Further research is needed into NSSH contagion; however, it is currently thought that showing recent NSSH wounds and discussing details of NSSH, such as the methods used, may trigger NSSH in others (Hasking et al. 2016).

> as the normal fluctuations that her interlocutor experiences . . . At times, no amount of tears, explanations and good will can convince the normal spouse, parent, or friend that the afflicted person's mental states are in fact what she purports them to be, as opposed to some childish charade that can be stopped with a little good old American effort. But a reassurance from a doctor that the suffer has a 'real illness' often changes all this. The afflicted person is reassured that she is not imagining things and she is not lazy or stupid or manipulative . . . While such an explanation as 'imbalance in the brain' is best for this purpose, giving the disorder an air of tangibility, a psychological hypothesis as to the etiology of the disease, or the statement that we do not know what causes the disease, are often perfectly acceptable—as long as one is not denied having an 'illness like any other illness' (Arpaly 2005, 296).

On Arpaly's view, being given a mental disorder diagnosis allows one to legitimise one's suffering to oneself and encourages others to show compassion. Considering NSSH in youth, then, as a mental disorder encourages compassion for the youth who engages in NSSH.

This is starting to show that collective well-being is improved by giving young people who engage in NSSH access to clinical assessment and intervention tools. Hence, Kukla's definition may imply that NSSH in youth is a disorder. Yet, I claim that NSSH in youth is never a mental disorder in its own right.

Collective welfare[50]

It appears that Kukla is only suggesting that phenomena should be defined as disordered to allow access to clinical assessment and intervention tools. I assume that Kukla's

[50] Kukla (2014) uses "well-being" and I use "welfare". For consistency I will now only use "welfare".

motivation is to allow people access to clinical tools without having to meet a natural or socially constructed kind of disorder. I am sympathetic with this motivation; however, I suggest that whether one has a mental disorder should not determine whether one is offered access to clinical assessment and intervention tools.

In this dissertation, I am interested in determining who should be offered funded clinical interventions, and in particular, who should be offered interventions from a specialist, secondary mental health service.[51] I want to say that if two people have the same disorder then one may merit an intervention while the other does not. Likewise, when two people have no disorder but present with the same phenomena, I suggest that one may merit an intervention while the other does not. Hence, for my purposes focusing on individual welfare and not collective welfare gives us the advantage of saying who should be offered an intervention.

Practical considerations

I now return to my claim that NSSH in youth is never a mental disorder in its own right. I discuss the negative practical consequences and practical motivations. This allows me to show that someone would be mistaken to try to use Kukla's definition to say that NSSH in youth is a disorder.

There may be negative consequences of saying that someone has a mental disorder. Telling someone she has a mental disorder may affect how she views herself, influence her actions and impact on how others view and respond to her (Hacking, 1995). Hence, it is

[51] I remind the reader that this question is the question of when it is good to offer interventions (see p. 7 where I explain this further).

important to make the right decision when deciding whether a phenomenon is a mental disorder.

My worry with saying that NSSH in youth is a mental disorder in its own right is that often a young person is using NSSH to try to cope with external problems and understandable yet distressing emotions and thoughts. To illustrate this, consider the composite case of John, a 15-year-old male. He seeks help from his school because he is being bullied for being gay and is told that he needs to stop being different. He then turns to NSSH to cope with the distress of the ongoing bullying and the reaction from his school. If John thinks that NSSH in its own right is a mental disorder, then, there is the worry that he will internalise the problem to be about himself, when the problem is an external one.

However, despite this worry, as I said earlier in this chapter (pp. 41-43), there are practical motivations for defining NSSH in its own right, across all ages, as a mental disorder. One practical motivation is to enable those who engage in NSSH to access funded treatment. Another is to ensure that those who engage in NSSH are not misdiagnosed with, particularly, borderline personality disorder. Also, a further practical motivation is to enable researchers to have a clear definition to allow more focused and improved research. I discuss these practical motivations in reverse order.

Firstly, one practical motivation for defining NSSH as a disorder is to have a single clear phenomenon that is able to be the subject of focused research. I agree that an NSSH diagnosis may provide a framework for a clearer understanding of what NSSH is, as a major weakness with the literature is that different classifications of NSSH are being used. A clearer understanding would lead to better research and further development of specific strategies to manage NSSH. As Brausch (2019, 83) says, once diagnostic criteria for NSSH are established the research is “likely to flourish”. However, there are many things that draw research interest without them having to be considered a disorder. For example, characteristic

youth behaviours such as binge drinking and smoking tobacco have drawn research interest. I hope, then, that considering NSSH an actual phenomenon is enough to encourage further research without having to consider it a mental disorder in its own right.

Secondly, I discuss the practical motivation that by having an NSSH diagnosis those who engage in NSSH avoid being misdiagnosed with, particularly, borderline personality disorder. I am not clear why this is a practical motivation. It appears to me that if people who are engaging in NSSH are being inaccurately diagnosed with borderline personality disorder then clinicians need to be educated more about borderline personality disorder. It does not have to follow that a symptom of borderline personality disorder, in this case NSSH, has to become a disorder in its own right to avoid a misdiagnosis. It appears to me that the question that may need to be considered by those who have this practical motivation is whether NSSH is a symptom of other mental disorders, such as depression or post-traumatic stress disorder, so NSSH needs to be included in the diagnostic criteria of other disorders.

Furthermore, I have a worry about this second practical motivation. My worry with this practical motivation is that it may, unintentionally, imply there is something wrong with having borderline personality disorder. This is because another disorder needs to be created to avoid the diagnosis. I doubt this is what those who have this motivation want to imply; yet, borderline personality disorder is already a very stigmatised disorder, so my worry is that this motivation is more open to a negative interpretation.

Thirdly, the practical motivation to enable those who engage in NSSH to access funded treatment is one I say more about. For many cases of NSSH in youth, funded mental health treatment is not needed. There are cases, however, in which NSSH in youth occurs alongside separate diagnosable mental disorders, such as depression, post-traumatic stress disorder and (with older youth) personality disorders. When NSSH occurs alongside a mental disorder, then, input from mental health services may be required to treat the mental disorder,

which might involve managing the NSSH. Likewise, there are many cases of binge drinking or smoking tobacco in youth where mental health treatment is not needed. Yet, there are cases when binge drinking or smoking tobacco occurs alongside a mental disorder, such as depression, anxiety and alcohol dependence. Similarly, input from mental health services may be required to treat the disorder that might involve managing the binge drinking or smoking tobacco.

Furthermore, it is not always the case that someone has to have a mental disorder to receive funded treatment. To make my point, consider the following examples that illustrate cases in which someone who *does not* have a mental disorder *does* require funded mental health treatment and in which someone who *does* have a mental disorder *does not* require funded mental health treatment.

Not having a mental disorder and requiring funded mental health treatment

First, I discuss an example that illustrates a case in which someone who *does not* have a mental disorder *does* require funded mental health treatment. Consider the hypothetical case of a person who is depressed following the loss of her romantic partner. She feels sad, emotionally empty and worthless nearly every day. She is tearful, eating less and does not gain pleasure from the things she used to enjoy doing. She is also tired and distracted. If she had received support from her family and friends early after the break-up, things may not have got this difficult for her. However, she did not receive any support from her family and friends. This is because she broke up with her girlfriend and she lives in a society in which homosexual relationships are viewed as wrong and shameful. In this society, if she was depressed over the loss of a boyfriend, she would be able to seek comfort in her family and friends. Yet, no one knows that she had a girlfriend, so she has dealt with the loss alone. Now this was someone very special, so she needs help to deal with her loss. There is a wider issue that needs to be addressed in this society, which is that homosexual relationships should not

be viewed as wrong and shameful. Also, I would not want to say that she is disordered for feeling depressed after a significant loss and then for her depressive state to worsen due to the society she lives in. She does, however, still require funded mental health treatment because she has a mental health problem, which she needs support for, and she is unlikely to get support from anywhere else other than a mental health service.

Having a mental disorder and not requiring funded mental health treatment

Now, I discuss an example that illustrates a case in which someone who *does* have a mental disorder *does not* require funded mental health treatment. Consider the hypothetical case of someone experiencing a high level of anxious thoughts about an area of their life. For example, consider a young person, who has many supportive non-clinician people in her life, such as her peers, teachers and family. Imagine she is experiencing a high level of anxiety about being out in public. The young person has always been anxious when out in public and this has progressively worsened. When the young person is out in public, she thinks that people are laughing at her or questioning her right to be out. She also thinks something awful will happen to her, her family or friends. She is motivated to try to overcome her anxious thoughts. She has positive relationships that are not negatively affected by her anxious thoughts. She lives in an environment that does not have a negative impact on her. This is a case where I would want to say she has a mental disorder, such as an anxiety disorder; however, she does not require funded mental health treatment because there are self-help strategies she is able to pursue with the support of her peers, teachers and family.

Before concluding again that NSSH in youth is never a mental disorder in its own right, I shall point out that an antagonist may use my analysis to say that NSSH in youth is a mental disorder in its own right. First, I remind us of my claim: I have argued that commonly seen, non-disordered, characteristic youth behaviours, such as binge drinking and smoking

tobacco, are similar in all relevant respects to NSSH in youth. These common phenomena are not mental disorders, in their own right, so there is a good reason to conclude that NSSH in youth is never a mental disorder in its own right, either.

My antagonist

Of course, my antagonist may reverse my analysis. It is feasible for my antagonist to use my analysis to say instead that commonly seen, characteristic youth behaviours, such as binge drinking and smoking tobacco, are similar in all relevant respects to NSSH, and that NSSH in youth is a mental disorder in its own right, so the relevant characteristic youth behaviours are mental disorders in their own rights too. If someone wanted to take this alternative position, then they may try to use evidence from the DSM-5 and suggest, for example, that youth smoking tobacco meet the criteria for Tobacco Use Disorder (American Psychiatric Association 2013, section II '*Substance-Related and Addictive Disorders*').

The result of saying that characteristic youth behaviours in youth are mental disorders would be that most, even perhaps all, youth would be diagnosed with mental disorders. This may not cause objection for some. However, on my view, this is an odd thing to say for two reasons.

Firstly, saying that characteristic youth behaviours in youth are mental disorders means that there is much more mental disorder around than commonly and clinically thought; suddenly, a whole population group is now disordered. This means youth who are experimenting with illegal drugs, staying out late and having unprotected sex have mental disorders. Also, police officers who discover youth engaged in characteristic youth behaviours, such as speeding or being drunk and rowdy at nightclubs, will be classifying these youth as disordered. Furthermore, teachers catching pupils engaged in characteristic youth behaviours, such as smoking behind the bike sheds and doing skateboarding tricks

without any protective clothing, will also classify these youth as having mental disorders. This appears to me to be intuitively odd.

Secondly, saying that characteristic youth behaviours in youth are mental disorders means that behaviours that are usually part of a passing phase and produce goods appropriate to that phase of life are mental disorders. This will result in human development during the adolescent years being considered one whole disorder, perhaps termed having a "characteristic youth disorder".

To illustrate this odd "characteristic youth disorder", consider the fictional example of Kevin the Teenager. "Kevin the Teenager" (hereafter referred to as "Kevin") is a character in the 1990s British comedy television programme '*Harry Enfield and Chums'* played by Harry Enfield.[52] In the clip when Kevin turns thirteen, he immediately loses rational thought and becomes rude towards his parents the moment the clock strikes midnight (BBC Studios, '*Kevin becomes a teenager'*). In the same clip, of the newly turned 13 year old Kevin, he says he wants to go out and his father gives him reasons why he is not able to, such as that it is midnight and dangerous for him to be out alone. After Kevin storms out of the room his father tries to reassure Kevin's mother that the change they have seen in Kevin "is only a phase [that] only lasts for four or five years" and they both end up in tears (BBC Studios, '*Kevin becomes a teenager'* 2:34).

In other clips, Kevin is seen engaging in characteristic youth behaviours, so, according to my antagonist, Kevin has characteristic youth disorder. Yet, Kevin recovers

[52] Kevin is also one of the main characters in a feature film called '*Kevin and Perry Go Large*'.

from the disorder without clinical intervention.[53] Kevin no longer has the disorder when he is portrayed in the television programme as waking up one morning no longer having characteristic youth behaviours, but instead he is polite and considerate towards his parents (BBC Studios, '*Kevin becomes a man*' 1:06). It appears to me to be intuitively odd to suggest that Kevin is able to have a mental disorder like most, even perhaps all, youth for a few years as part of his development and then recover without any clinical intervention as he matures.

Theoretically, then, my analysis may be used to say that NSSH in youth is a mental disorder in its own right. However, this results in intuitively odd conclusions about the nature of mental disorder. It is intuitively odd to say that there is much more mental disorder around than commonly and clinically thought. Furthermore, it is intuitively odd that behaviours that many people display for a few years and that produce goods for that time in one's life are mental disorders. Also, as I said earlier in this chapter (pp. 68-72), there are negative practical consequences of using my analysis to say that NSSH in youth is a mental disorder in its own right.

To conclude my argument again

To conclude my argument, there are practical motivations for classifying NSSH, across all ages, as a mental disorder in its own right. I have tried to show that it is feasible that these motivations can be met without saying that NSSH, across all ages, is a mental disorder in its own right.

[53] Kevin matures by losing his virginity, which I, and likely many, would consider odd to prescribe as a clinical intervention.

If it is *not* feasible, then, in my view when considering whether NSSH in youth is a mental disorder in its own right, the practical motivations are outweighed by three other considerations.

Firstly, NSSH in youth is a characteristic youth behaviour. I consider "characteristic youth behaviours" to be behaviours that present temporarily, as part of a passing phase, and produce goods appropriate of adolescence. Often characteristic youth behaviours require management, which may include treatment, but these behaviours are not mental disorders in their own right. I have argued that commonly seen, non-disordered, characteristic youth behaviours, such as binge drinking and smoking tobacco, are similar in all relevant respects to NSSH in youth. This means that if NSSH in youth in its own right is defined as a mental disorder there is a risk that other characteristic youth behaviours will also be considered mental disorders. A consequence of this is that many, even perhaps all, youth will be considered disordered and this will result in pathologising the youth years.

Secondly, pathologising characteristic youth behaviours will mean that most, even perhaps all, will be considered disordered for the usual development seen in youth. I have shown that developmentally appropriate characteristic youth behaviours are part of a passing phase and produce goods. This means that if NSSH in youth in its own right is defined as a mental disorder, then there is a risk that other behaviours that are usually part of a passing phase and produce goods appropriate to that phase of life will also be considered mental disorders.

Thirdly, NSSH in youth has, in many cases, an understandable practical function. Youth often use NSSH to try to cope with external problems and understandable yet distressing emotions and thoughts. During this stage of one's life, many youth experiment with different approaches because they are developing an array of different skills. Youth are learning ways to cope and manage distressing emotions and thoughts. This means that youth,

perhaps, habitually resort to using ways to cope that may be destructive, abnormal and irrational. It is odd to say that youth, who often have a lot to manage without the array of adult coping skills, have a mental disorder for trying to cope in the best available way to them.

Hence, it should hold that characteristic youth behaviours in youth are not mental disorders, so NSSH in youth is never a mental disorder in its own right. This means if NSSH is included in diagnostic manuals as being a separate diagnosable mental disorder, then, I strongly recommend that there is the inclusion that youth are not able to receive this diagnosis.

Chapter three: the question of intervention

The question of intervention

In chapter two, I argued that non-suicidal self-harm (hereafter referred to as "NSSH") in youth is never a mental disorder in its own right. Yet, when I say that NSSH in youth is not a disordered behaviour I am not saying that it never merits intervention. NSSH in youth is a characteristic youth behaviour that may have negative and sometimes dangerous consequences. Physical injury may include minor scratches, open wounds, infection, scars, nerve damage, broken bones, liver damage and accidental death. Negative psychological consequences may include reinforcing unwanted negative self-beliefs, and feelings of shame and guilt. Other negative consequences may include damage to relationships and a damaging impact on the person's ability to achieve her goals. Also, NSSH, like some other non-disordered acts, may turn out to be a symptom of a mental disorder, or lead to a mental disorder or suicidal behaviour. As with other characteristic youth behaviours, NSSH needs to be managed, even if it is not a mental disorder. At times, that management involves interventions offered by specialist, secondary mental health services.

A common view is that interventions by specialist, secondary mental health services should only be offered when a person has a mental disorder. When I say that the management of NSSH in youth sometimes involves interventions from these services I am challenging this assumption. Also, in chapter two (pp. 71-73), I started to challenge this assumption when I said that it is not always the case that someone has to have a mental disorder to receive funded treatment. I made this point in response to the practical motivation of considering NSSH, across all ages, a distinct mental disorder to enable those who engage in NSSH to access funded treatment. I said that sometimes funded mental health interventions should be

offered to someone who does not have a mental disorder, and sometimes they are not required by someone who does have a mental disorder.

In chapter five I progress this discussion by asking the question: who should be offered interventions from a specialist, secondary mental health service?[54] When discussing the question, I will continue to use the example of NSSH in youth. I will also use the example of unruliness in children and youth. I explain "unruliness" in the next chapter. Before I turn to this question, in this chapter, I spend some time explaining what "specialist, secondary mental health services" are, and detail my definition of "specialist, secondary mental health services". I then explain the importance of focusing on specialist, secondary mental health services. Lastly, I discuss a widespread assumption that it is only those with mental disorders who warrant interventions from specialist, secondary mental health services.

Explaining "specialist, secondary mental health services"

To explain what I mean by "specialist, secondary mental health services" I first use a personal example from the physical domain.

I have diabetes. Before I was diagnosed I noticed I was feeling extremely tired; I found myself falling asleep during the day. I was very thirsty and frequently needed to urinate. I also had nausea. I was concerned, so I visited my general practitioner. During my appointment, my blood was tested with a monitoring device and I provided a urine sample. The general practitioner and nurse informed me they were concerned that I had excessive glucose in my blood and a high level of ketones in my urine.[55] My general practitioner and

[54] I remind the reader that this question is the question of when it is good to offer interventions (see p. 7 where I explain this further).

[55] Ketones are acids that the body releases when it is unable to use glucose.

nurse suspected I had diabetes, but they did not have the specialist training to confirm their suspicions or offer initial treatment. They said I required emergency treatment because I was in a life-threatening situation, so I was admitted to hospital. Following treatment from the emergency department I was transferred to a general hospital ward.

I was then referred to my diabetes specialist team, which is a secondary service. I met my diabetes specialist nurse and doctor while in hospital. They diagnosed me as having diabetes. When I was discharged from the hospital, I met my diabetes specialist nutritionist. I continued to see my diabetes specialist nurse, doctor and nutritionist as an outpatient. I would visit the specialist, secondary diabetes service to be monitored, to be prescribed my pharmacological intervention of insulin, to discuss how to manage my diabetes alongside my lifestyle and learn the intervention of insulin adjustment. Once I was on the most effective insulin for me, my glucose levels were under control and I had learnt how to adjust my insulin, I was discharged from the specialist, secondary diabetes service. The team wrote to my general practitioner about how to continue monitoring my diabetes, what to prescribe me and when to refer me back to the diabetes team clinicians, if needed.

I recognise that not all cases in the physical domain move between services as smoothly as I did. My personal example is simply being used as a comparable case. I will now turn to a hypothetical example from the mental domain.

Imagine Rose, a child who has concerns. She is feeling extremely tired and often becomes tearful. She expresses that she is worried. Rose's parents have noticed that she has become picky about what she eats and refuses to have a full meal. Her parents take her to their general practitioner, who expresses concerns about Rose having lost some weight. In the classroom she has become quieter, and her teacher has concerns about Rose not following the schoolwork. The teacher also notices that Rose does not want to play with her friends

anymore. The child, parents, general practitioner and teacher all have concerns. Rose's presentation is concerning but not life threatening.

The question of when to refer Rose to a specialist, secondary mental health service is not clear. As Rose is a child the adults take a lead in deciding what to do. They wonder whether Rose is going through a phase that will pass without intervention. The adults consider whether to encourage Rose to engage in activities that may make her feel happier, such as sports, art and music. Her parents have found some self-help resources online about children who worry, and they wonder whether they should show them to Rose. Rose's teacher is considering inviting her to the next school group on friendships. Her general practitioner questions whether Rose needs to see, perhaps, a psychiatrist about the concerns related to her eating. Her parents wonder whether the self-help resources will be suitable or whether she needs an intervention from, say, a psychologist. Rose's teacher queries the group she is offering to Rose and wonders whether Rose should, instead, attend a group run by, maybe, a clinical social worker. What the adults in Rose's life are doing is questioning whether they should make a referral for Rose to access a funded intervention from a psychiatrist, psychologist or clinical social worker at the child and adolescent mental health service, which is a specialist, secondary mental health service.

What is a "specialist, secondary mental health service"?

I recognise that the term "specialist, secondary mental health services" may be used in different ways. It is important, then, that I clarify how I will be using the term in this dissertation. I start by providing my definition of "specialist, secondary mental health services". Next, I clarify what interventions may be offered by these services. Lastly, I explain what interventions are not offered by specialist, secondary mental health services.

Here is my definition:

> "Specialist, secondary mental health services" are, usually, multidisciplinary teams. Clinicians in the team will include those such as psychiatrists, clinical psychologists, clinical social workers, mental health nurses, family therapists and similar practitioners. These services are funded by the government. To access these services usually a person requires a mental disorder diagnosis. These services are not emergency services.[56]

To aid my explanation of what interventions may be offered by "specialist, secondary mental health services", consider the example of Alex. Alex is fourteen years old and has concerns that warrant an intervention. The details of the concerns are not of importance for the explanation. Alex may be overcome with sadness, be crippled with fear or have uncontrollable anger. Perhaps Alex has suicidal thoughts or thinks they are being persecuted despite the lack of evidence. It could be that Alex is soiling or harming themselves, or being violent toward others. What is of importance is that Alex's presentation warrants an intervention.

Interventions offered by specialist, secondary mental health services

If Alex is offered an intervention from a specialist, secondary mental health service this means the intervention needs to be delivered by someone with suitable and specialist training and qualifications in this field. For instance, Alex may require a pharmacological intervention, such as antipsychotics, mood stabilisers or antidepressants that require prescribing and monitoring by a psychiatrist rather than a general practitioner. Alex may be offered a talking-based intervention, such as a therapeutic group, which is delivered by a

[56] The definition is based on services in Aotearoa New Zealand and the United Kingdom.

clinical social worker who has specialist training in trauma work rather than, for example, a mentor.[57]

Specialist, secondary mental health services may offer their interventions in different settings. For example, Alex may access an intervention from a clinic attached to a general hospital. They may also see a clinician who offers appointments in community venues. For instance, a mental health nurse may work for a specialist, secondary mental health service and provide interventions in schools and colleges. Furthermore, Alex may access interventions from specialist, secondary mental health services in settings that involve staying for nights, weekends or longer. Alex may, for example, stay in a hospital or live in a therapeutic community where they receive daily interventions.

Interventions not offered by specialist, secondary mental health services

Interventions that are not offered by specialist, secondary mental health services include those that do not require someone to have suitable and specialist training and qualifications in this field. For instance, Alex may be encouraged by their parents to pursue interests such as swimming, football, dance or photography. Alex may seek interventions from self-help resources online. A teacher may ask Alex to participate in a group they run to help children and youth develop strategies to manage their emotions, thoughts or behaviours. Alex's school may also be able to offer them sessions with a counsellor. Furthermore, Alex's

[57] This is not to say that general practitioners and mentors, or similar are not trained or qualified to do their roles; instead, they do not have the same training and qualifications as those clinicians working at specialist, secondary mental health services. It is feasible that a mentor, for example, may have the same training and qualifications as a clinician working for a specialist, secondary mental health service; however, the mentor would not offer the same interventions as the clinician because it is not their role.

general practitioner may offer a waiting approach. The action of waiting is not the same as taking no action because Alex, the general practitioner and other adults in Alex's life are still monitoring the concerns. The waiting approach is to see whether the concerns pass, continue or become worse. All these are the kinds of interventions that need not be offered by specialist, secondary mental health services.

An intervention not offered by specialist, secondary mental health services might have a focus on wider social influences. For instance, maybe, Alex's circumstances are contributing to their concerns. Alex is, perhaps, living in poverty, experiencing abuse or facing discrimination. Alex, then, receives an intervention that is directed at their situation. For example, Alex's intervention may include a change that tackles them living in poverty, police action taken against an abuser, or a change in societal attitudes so they no longer experience discrimination. The focus of the intervention, then, is directed at a wider change of social circumstances, which is not offered by specialist, secondary mental health services.

Summary

To summarise, interventions offered by specialist, secondary mental health services are delivered by someone with suitable and specialist training and qualifications in this field. The interventions may be offered within a variety of different settings. The interventions do not include a focus on changing social circumstances, such as tackling poverty.

It is important to note that Alex may be offered a variety of interventions. For instance, they may be offered an intervention by a specialist, secondary mental health service alongside receiving encouragement from their parents to pursue their interests, such as swimming, football, dance or photography. The specialist, secondary mental health service may also support Alex to approach the police to take action against an abuser. The specialist, secondary mental health service may additionally make a referral to a community

organisation to assist Alex and their family with the challenges of living in poverty, such as advocating for better housing.

The importance of focusing on specialist, secondary mental health services

I end this section of the chapter by explaining why I am asking who should be offered interventions from a *specialist, secondary mental health service* in particular. There are three predominant reasons.

Firstly, from my clinical experience, most children and youth who are referred to these services are presenting in extremely concerning ways. They may have not left their homes in days, weeks or even months. They may be struggling to find the motivation to eat. Some children and youth are violent towards others, severely harm themselves, act out traumatic events, smear faeces on walls or collect their urine. At times children and youth are turned away from these services, leaving referrers often questioning the reason. This may lead to a child or youth, and the adults in their life, receiving inappropriate interventions from elsewhere or with no support. This then may lead to a deterioration in the welfare of the child or youth, which also negatively impacts others, like family members, peers and teachers.

On the other hand, in some cases, it is beneficial to not offer interventions from a specialist, secondary mental health service. For instance, if a child is presenting with concerns then the adults in her life may be able to help without input from a specialist, secondary mental health service. If the adults are able to assist, then they can show her the many ways to address concerns. Furthermore, they show her that there are important and constant people in her life who have the means to help, and that some emotions, thoughts and behaviours are part of her development and are to be expected.

Secondly, another reason why it is important to ask who should be offered interventions from a specialist, secondary mental health service, in particular, is that these

services are funded by the government. This raises a question of justice and a further question about efficiency. Funding from the government removes a financial barrier to accessing interventions from these services. I assume that having access to mental health interventions in a just state would include the right to access services without financial barriers. It is also important to question who should be offered these interventions to ensure the service makes efficient use of the funding. This questioning ensures the funding is not wasted and is directed towards those who most need or deserve it.

Lastly, another important reason is that "medicalisation" occurs in specialist, secondary mental health services. I am using the term "medicalisation" here to say that these services categorise a presentation of emotions, thoughts and behaviours as being of medical interest. This leads to presentations being defined as disordered and considered treatable, and draws research interest in understanding the presentation and developing interventions. I think that medicalisation occurs in these services rather than at the point of primary care because of the specialist training and qualifications of those who deliver specialist secondary care.

It is important to ask questions about services where medicalisation occurs because "medicalisation" has moral implications. On moral implications, the philosopher Quill Rebecca Kukla (writing as Rebecca Kukla 2014, 518) says:

> medicalization is not a normatively neutral process. On the one hand, it often effects a shift in moral valence: What was previously seen as a character flaw comes to be seen as a form of illness protected from the logic of personal responsibility, and requiring management by experts instead. (Consider what happened when we started thinking of alcoholism and other forms of addiction as diseases, or when we started conceiving of "hyper" children as having ADHD.)

Medicalisation has consequences, such as how someone is viewed and what personal responsibility they hold.

There is a lot at stake, then, for determining who should be offered interventions from a specialist, secondary mental health service.

Summary

I have spent some time explaining and defining "specialist, secondary mental health services". My aim is not to provide a definition that has clear boundaries. Instead, I want us to have some common familiarity with the term. I have also explained the importance of asking the question with a focus on specialist, secondary mental health services by showing what is at stake.

The assumption

In chapter five I ask: who should be offered interventions from a specialist, secondary mental health service? I claim that whether one has a mental disorder should not determine whether one is offered a mental health intervention. This does not imply that clinicians should not ask what mental disorder is. Instead, my claim is that mental disorder is not a single determinant of whether interventions by clinicians is warranted. By asking the question I challenge the assumption that it is only those with mental disorders who warrant interventions from specialist, secondary mental health services. In this section, I will explain the assumption.

Children and youth

In a way, some children and youth assume that specialist, secondary mental health services only offer intervention for those who have a mental disorder. For instance, consider the composite case of Sophia. Sophia is eight years old. She is offered an intervention from a

specialist, secondary mental health service. Sophia is regularly attending the sessions, but one day she refuses to go. Her teacher asks her why she does not want to see the clinician. Sophia explains that some of her classmates have started to call her “loony toons”. Sophia is then persuaded to keep attending the sessions. She wants to spend the time with the clinician questioning whether there is something wrong with her. The classmates are unlikely to use the term “mental disorder”, but, perhaps, by using “loony toons” they are inferring that Sophia has a disordered mental state. The term “loony toons” may be replaced with “mental”, “crazy”, “loopy”, “demented”, “fruitcake”, “bonkers” or similar terms. There is a separate issue here of the children referring negatively to someone they consider to have a mental disorder. However, for my purposes, I will point out that there is an assumption from the children that Sophia is being offered an intervention from a specialist, secondary mental health service because she is disordered in some way. The assumption is that those offered interventions from a specialist, secondary mental health service have something wrong with them or have mental disorders.

Now consider another composite case. Lucas is twenty years old. His younger brother has been diagnosed with a mental disorder and is accessing interventions from a specialist, secondary mental health service. One of the interventions is family therapy, which Lucas attends with the rest of the family. Lucas says he may, perhaps, benefit from an individual intervention for his low mood, but he does not consider himself to be depressed. Lucas does not use the term “mental disorder”, but he implies he does not have a mental disorder by saying he does not think he has depression. This indicates, then, that Lucas is wondering whether someone is only offered an intervention when they have a mental disorder.

It is very likely that many children and youth assume that specialist, secondary mental health services only offer interventions for those that have a mental disorder, in part, because of the view promoted by clinicians and policy makers.

Clinicians and policy makers

In the introduction (pp. 1-6) I used the composite case of a referrals meeting, and then the clinical evaluation of Luke, to illustrate that often the question of whether someone should be offered interventions from a specialist, secondary mental health service is linked to the question of whether one has a mental disorder. There are many people in need of help and support and clinicians are not in a practical position to be able to intervene with everyone in need. Their resources are limited; hence, questions of distributive justice are raised, so when determining what they are practically able to offer there are boundaries placed on their services. One boundary is that specialist, secondary mental health services will only offer interventions for those who have a mental disorder.

"Child and adolescent mental health services" is a specialist, secondary mental health service. The service is often referred to as "CAMHS" and, may also be known as "infant, child and adolescent mental health services" or "infant, child, adolescent and family services".[58] There is material in the public domain about child and adolescent mental health services that promotes the assumption that phenomena must be mental disorders in order for these services to offer interventions.

For instance, a service in the United Kingdom promotes the message to the public to access help when someone has a "mental health problem" (Chesterfield Royal NSH Foundation Trust 2018). Their webpage does not use the term "disorder", but this is implied when they say that "There are many different mental health problems, and some symptoms are common to more than one diagnosis" (Chesterfield Royal NSH Foundation Trust 2018, '*Getting help with your mental health*' section). Furthermore, they list "main mental health

[58] The infant, child and adolescent mental health services is often referred to as "ICAMHS", and "ICAFS" is commonly used for the infant, child, adolescent and family services.

problems" to include what are commonly thought to be mental disorders, such as depression, obsessive-compulsive disorder, eating disorders and psychosis (Chesterfield Royal NSH Foundation Trust 2018, '*Getting help with your mental health*' section). Although the webpage, then, does not explicitly say that phenomena must be mental disorders in order for them to offer interventions, this is certainly implied.

Another example is from a child and adolescent mental health service in Aotearoa New Zealand. On their webpage it says they are a service for those with "serious mental health disorders and suspected psychiatric disorders" (Nelson Marlborough Health 2020, para.1). It is not clear what the difference between a mental and psychiatric disorder is, but this example is more explicit about only offering interventions for those with mental disorders.

A further example of the assumption is from a job description. This job description is for a "Clinical Specialist Nurse Intake Co-ordinator" within a child and adolescent mental health service in Aotearoa New Zealand (Taranaki District Health Board 2016).[59] Part of the role is to screen referrals made to the service to assess suitability. The purpose of the role is explained as being "responsible for providing assessment and co-ordination of service provision for children, young people and their families and whanau referred to Child and Adolescent Mental Health Services (CAMHS) with serious mental illnesses and disorders" (Taranaki District Health Board 2016, 1).[60] This example explicitly mentions "mental illnesses and disorders". It is feasible that mental disorders are not the *only* things that this

[59] The job description was captured during an Internet search on September 15, 2020.

[60] Whānau is often translated to English as "family" or "extended family", but it is a Māori term that goes beyond this translation.

service offers intervention for, but it is strongly implied that the service is for those with mental disorders.

The above examples are representative of a very common attitude seen in practice and encode the assumption that specialist, secondary mental health services only offer interventions for those who have mental disorders.

In some countries there are clear contractual arrangements to fund services to deliver interventions only in relation to mental disorders. For instance, there are national service guidelines for child and adolescent mental health services in Aotearoa New Zealand that explicitly say services are for those with disorders. The government's Ministry of Health (2018) provides mandatory service specifications for local health bodies on delivering services for infants, children and youth. The guidelines (Ministry of Health 2018, 2) are specifically for those up to 20 years old; however, it is noted that there may be individual contract agreements to manage transitions to adult services for those up to 25 years old. The guidelines (Ministry of Health 2018, 2) say "Infant, Child, Adolescent and Youth Mental Health Alcohol and or other Drugs Services" are specifically for those "with, or suspected of, having a mental health and / or alcohol and other drug disorder". The services are also for those with "psychological disorders" and those "seeking information about mental ill health" (Ministry of Health 2018, 2-3). The guidelines do not define "mental health disorder", "alcohol and other drug disorder", "psychological disorder" or "mental ill health". However, what is clear is that services are being contracted to provide interventions in relation to disorders, whatever a disorder may be. Hence, the assumption that it is only those with a mental disorder who warrant interventions from specialist, secondary mental health services has current funding implications.

The literature

The assumption that it is only those with mental disorders who warrant interventions from specialist, secondary mental health services is not defended by philosophers. However, philosophers have pointed out there may be a more general assumption that phenomena must be disorders in order for medical interventions to be offered. The philosophers Rebecca Roache and Julian Savulescu (2018, 246) say the "'pathologization' of normal human traits" is motivated by the assumption that phenomena must be disorders to be "medically improved". Furthermore, they say that treating disorders is "widely taken to be the primary focus of medicine" (Roache and Savulescu 2018, 248).[61]

The assumption that phenomena must be disorders in order for interventions to be offered is also identified by the philosopher Lisa Bortolotti (2020). Similarly to Roache and Savulescu (2018, 248), Bortolotti (2020, 164-165) points out that there is a wide view that the primary goal of medicine is to treat and prevent disorders. She says that according to this view "the notion of disorder is key to establishing what deserves medical attention and medical care" (Bortolotti 2020, 164).

Although Bortolotti sees this as an assumption, she rejects it. She claims that "the answer to what counts as pathological (or disordered) does not always work as an answer to what deserves medical attention" (Bortolotti 2020, 164). In her work, she focuses "on the distinction between normal and the pathological as applied to delusions" and says that "It is hard to provide a coherent answer to what makes delusions pathological that also explains why delusions are typically the appropriate target of medical attention" (Bortolotti 2020, 164).

[61] In chapter six (pp. 162-164 and p. 166) I come back to Roache and Savulescu's work (2018).

I am not suggesting that the assumption is widespread across practice in healthcare. As noted even by Roache and Savulescu (2018, 248) a lot of healthcare operates without any reference to disorder, such as in obstetrics and optometry. The assumption I am discussing in this dissertation is specifically about those who receive specialist, secondary care regarding mental health. The assumption is that it is only those with a *mental disorder* who warrant interventions from *specialist, secondary mental health services*.

Conclusion

In conclusion, an assumption that acts as a prominent answer to the question of who should be offered interventions from a specialist, secondary mental health service is "those with mental disorders". In chapter five I will continue to challenge this answer. First, I should explain "unruliness", which is the other case I am using in this dissertation. In the next chapter, then, I explain "unruliness" and compare it to NSSH.

Chapter four: what is unruliness?

"Unruliness" and "unruly behaviour"

There are many examples of unruliness in children and youth. For instance, unruly behaviour includes a wailing toddler who is disruptive by refusing to put on their pyjamas, a child who shows their disobedience by dragging their feet to get in line at school and the youth who shows defiance by arriving home past their curfew wearing something different to what they left the house in. Other unruly behaviours include deliberately breaking items, stealing, and having physical fights. Furthermore, unruly behaviours include crossing police lines when protesting, and attempting to gain an education when this goes against social norms and law.

Unruliness is also seen in adults. Adults too may deliberately break items, steal, have physical fights, cross police lines, and break local law and social norms. Other unruly behaviours seen in adults (and in older youth) include being argumentative, disobedient, defiant or disruptive with romantic partners, and not following requests and orders from employers.

I recognise that "unruliness" is used in different ways, so here are the definitions I am using in this dissertation.

"Unruliness" is having a disposition to display "unruly behaviour".

"Unruly behaviour" includes not following requests and orders from authority figures, such as parents, teachers and the police. Furthermore, "unruly behaviour" includes breaking or rebelling against rules and social norms. Also, "unruly behaviour" is being argumentative, disobedient, defiant or disruptive.

Family resemblances

Under the term "unruliness" I have included different concepts; these include rebellion, and being argumentative, disobedient, defiant and disruptive. All these different

concepts are difficult to distinguish from each other in practice, so, for my purposes, I have grouped them as "family resemblances" under the term "unruly behaviour". To explain "family resemblances", I borrow the philosopher Nancy Nyquist Potter's (2016, 1-2) concise explanation of the philosopher Wittgenstein's work.[62] "Family resemblances are concepts that, like members of a family, have enough properties or characteristics in common to group them together, yet are somewhat separate in their own right too (Wittgenstein 2009, 36, section 67)" (Potter 2016, 1). Wittgenstein explains the idea of family resemblances by using the example of games. There is a wide range of different kinds of games that share to a varying degree similar properties and, despite the variety, we know what we are talking about when we say "games". On this idea, we do not need to identify necessary and sufficient conditions of games. Likewise, on this idea, I do not need to identify the necessary and sufficient conditions of unruly behaviour.

Diagnosable mental disorders

Unlike non-suicidal self-harm (hereafter referred to as "NSSH"), unruliness in its own right sometimes meets the diagnostic criteria for a mental disorder. For instance, both the latest versions of the '*International Classification of Diseases*' (ICD-11) and the '*Diagnostic and Statistical Manual*' (DSM-5) contain "oppositional defiant disorder" (hereafter referred

[62] Potter (2016, chapter 1) uses Wittgenstein's work to draw attention to defiance being part of a family that include medical concepts, such as compliance and noncompliance. I come to Potter's work shortly.

to as “ODD”) and “conduct disorder”.[63] To simplify the criteria from the ICD-11 and DSM-5, here is a summary of ODD and conduct disorder.[64]

> “ODD” is a persistent pattern of anger, irritability, argumentative behaviour, defiance or vindictiveness towards at least one person who is not a sibling that has lasted for at least six months. The person that this mood and behaviour are directed towards is an authority figure or, for children and youth, an adult. The behaviour needs to result in a significant impairment in an important area of the life of the person who has the disorder.
>
> “Conduct disorder” is a persistent pattern of disruptive and violent behaviour such as violence towards people or animals, forcing others into sexual activity, destruction of property, deceitfulness or theft, and serious violations of rules. The behaviour needs to result in a significant impairment in an important area of the life of the person in order for the person to have the disorder.

Both the ICD-11 and DSM-5 provide the option of receiving a diagnosis if someone presents with the symptoms that are characteristic of this category but do not meet full criteria.

ODD and conduct disorder are commonly diagnosed mental disorders for children and youth (Coghill 2013, 921). It is reported that “studies in the [United States of America] suggest that around 10% of children suffer from ODD and similar numbers from [conduct disorder]. Data from the [United Kingdom] estimates that around 6% of children and young people aged 5 to 16 years have a clinically diagnosed conduct disorder in England” (Coghill

[63] The ICD-11 (World Health Organization 2019, section 6C91) refers to conduct disorder as “conduct-dissocial disorder”.

[64] Refer to appendix two for detailed diagnostic criteria.

2013, 921). Others say that the prevalence of conduct disorder is around 3% in children and youth who are school-aged (Fairchild et al. 2019, 1).

The unruly behaviour seen in conduct disorder is likely to persist into adulthood. It is suggested that around 50% of those with conduct disorder "show desistance or remission of symptoms" while the rest "have chronic symptoms and develop personality disorders and criminal behaviours in adulthood" (Fairchild et al. 2019, 1). I should point out that showing "desistance or remission" does not have to mean that the person is no longer displaying unruliness; what is implied is that the person no longer meets diagnostic criteria or they abstain from criminal behaviours.

Similarly, it is likely those with ODD will continue displaying unruly behaviour into adulthood. Some researchers offer the picture that:

> Although ODD is characterized as a disorder of childhood, it seems likely that these difficulties would not simply cease upon reaching adulthood. Rather, it seems more plausible that individuals with ODD likely continue to demonstrate problematic behavior during interactions with peers, coworkers, bosses and customers, and would have problems maintaining jobs and relationships (Burke, Rowe and Boylan 2014, 265).

Furthermore, the research that has been done with older youth does indicate that it is likely that problems with relationships, such as with peers, family members and romantic relationships, will persist into adulthood (Burke, Rowe and Boylan 2014, 265 and 271). Again, the important point to note is that someone may no longer meet the diagnostic criteria for ODD but continue to display unruliness.

Hence, the research paints the picture that many children and youth who are diagnosed with ODD and conduct disorder are likely to persist with unruly behaviour into

adulthood. This is a contrast to the picture of NSSH in youth, which I said is a characteristic youth behaviour.

A passing phase and useful for development

In chapter two I said that NSSH is a characteristic youth behaviour. I use the term "characteristic youth behaviours" to refer to behaviours that present temporarily, as part of a passing phase, and produce goods of adolescence (see pp. 44-47 where I explain the term further). I am not suggesting that it is necessary for every youth to engage in characteristic youth behaviours to have a good human life; however, there are reasons to think that engaging in these behaviours is good for some people during adolescence. Similarly, unruly behaviour may be part of a passing phase and produce goods of adolescence. However, unlike NSSH, unruly behaviour may also produce goods of childhood.

Unruliness is instrumentally valuable because it helps with development.[65] To illustrate, consider Maia's development. Maia is a toddler. She refuses to follow the requests of her parents, rebels against their rules, and is argumentative, disobedient, defiant and disruptive. She has daily arguments with her parents about why she is not allowed ice-cream for breakfast. She often reaches into her brother's cot when he is asleep, hits him on the head and runs away giggling. Every day she refuses to stop climbing on the rocks in the garden. Additionally, her parents prepare for the bedtime battle every night. The battle involves tears,

[65] There are resources for parents that describe unruly behaviours that are expected in children and youth. For example, there is a section on the different stages a child goes through on a parenting advice website (Parent Help 2018). Also, for a discussion about risk taking in adolescence helping with development, which includes unruly behaviour, see Duell and Steinberg (2019).

shouting and lots of foot stomping from Maia. Despite the disruption, this behaviour is developmentally expected. Maia is experimenting with social interactions with her ice-cream demands, hitting her brother and bedtime battles. She is also exploring her environment and physical abilities by climbing rocks. Furthermore, her unruliness allows her to develop her identity and place in her world. For instance, her ice-cream arguments and bedtime battles aid her understanding of the place she holds in her family. She learns her parents care about her and are in charge when it comes to important matters, such as her nourishment and sleep. Lastly, the reason why there is a repetitive nature of her unruliness is to allow her to learn.

Now consider Maia as a school-aged child. She still refuses to follow the requests of authority figures, rebels against rules, and continues to be argumentative, disobedient, defiant and disruptive. Additionally, she breaks social norms. However, her unruliness takes a different form from the tantrums of her toddler years. Now Maia argues with her parents when she is asked to turn off the television or pick up her clothes. Furthermore, she shows her defiance by doing things extremely slowly. For instance, her household chores take twice as long. At school she shuffles her feet when she is told by the teachers to get in line. Plus, she dawdles when out food shopping with her grandparents. Once again, this behaviour is developmentally expected. Maia's unruliness is building on the development of her identity and place in the world. She is establishing what her limits are and the limits of adult authority. She is also trying to exert control in her world and declare her independence.

During adolescence Maia's unruliness peaks. Her unruliness takes the form of a combination of the tantrums of her toddler years and the dawdling of her older childhood years. She has daily arguments with her parents for what sometimes appears just to be for the sake of arguing. When angry with her brother she thumps him in the arm. She refuses to stop jumping off high bridges into rivers with her friends. Additionally, her parents prepare for the breaking of curfew battle every weekend. The battle involves tears, shouting and lots of door

slamming. Furthermore, she has got even slower. For instance, now chores take days to complete. As with her younger years, Maia's unruliness is developmentally expected. She is still experimenting with her social interactions, exploring her environment and physical abilities, and developing her identity and place in her world. She still needs to establish her limits and the limits of adult authority. Likewise, her developmental needs to exert control in her world and declare her independence are still present. Hence, Maia's unruliness is instrumentally valuable because it helps with her development.

Defiance is a virtue

There is the view that defiance is a virtue. I remind the reader that I include defiance in "unruly behaviour".

The philosopher Nancy Nyquist Potter (2016) argues that the readiness to be defiant is a virtue. Potter uses the ancient philosopher Aristotle's virtue ethics. However, she says that "Aristotle certainly would not praise defiance, as it would be considered to be disruptive to the functioning of an ancient well-ordered society" (Potter 2016, xv). As a result, she modifies Aristotle's theory (Potter 2016, especially chapters 2, 3 and 5). This allows her to call defiance a virtue, which is "something worth cultivating in ourselves and worth valuing in others" (Potter 2016, xix). Furthermore, her adaptation allows her to argue that "like other virtues [defiance] is a necessary condition for living a relatively flourishing life" (Potter 2016, 5).

Potter (2016, 107-109) offers some good reasons to be defiant. One reason she offers is that "behaving defiantly can give hope to the downtrodden, the discouraged, and the underprivileged. Being defiant both expresses hope, and in expressing it, gives one hope—and hope is necessary to survive struggle" (Potter 2016, 107). She goes on to say that "Despair and hopelessness are an abandonment of the future, inculcating a passivity or even

destructiveness" (Potter 2016, 108). To illustrates this point Potter (2016, 67-70) provides the case of "Marie".[66]

Marie is described as "numb and paralysed" with depression by a clinician (Potter 2016, 67). She is admitted to hospital following an accidental overdose of heroin and while in hospital refuses to attend the therapy groups (Potter 2016, 67). In Potter's (2016, 108) analysis of Marie's defiance, she says that the clinician considers the refusal to be a "positive sign of engagement with the world". Potter (2016, 68) says that:

> Marie is not merely refusing to go to groups from a well-reasoned position where she has weighed various pros and cons and decided to make a decision not to go to group. Instead, she has tapped into anger about her depression and the seeming hopelessness of her condition. That anger breathes life into her in a way that rejects a despondent, numb self. In refusing to go to groups out of anger and rage, Marie engages her own stronger self. And a central part of expressing that angry self is that she moves towards defying norms of the patient role, of depressed women as dependent and helpless, and even the norm that psychiatric hospitals can begin to heal patients through socializing them. The distinction between the right to refuse treatment and the expression of defiant acts is blurred here, but the markers that Marie is exhibiting defiance are her passionate engagement with her own stronger self—something that was itself depressed for most of her life.

Being defiant is giving Marie hope that she has another way of being other than depressed.

Furthermore, the philosopher Kenneth Aggerholm (2020) uses a modified account of Aristotle's theory to claim that defiance in sport is a virtue. He uses defiance "in the ordinary sense of showing resistance or disobedience, and in a broader sense of acting in spite of

[66] Potter has borrowed this case from Lauren Slater (1996).

something and doing something nonetheless" (Aggerholm 2020, 1-2). He distinguishes between three forms of defiance. As I understand the forms, the first two do not capture how I am applying defiance in the term "unruly behaviour".

The third kind of defiance does fit the defiance I am describing. This is "rebellious defiance" (Aggerholm 2020, 11-13). This kind of defiance is "counteracting unjust authority" (Aggerholm 2020, 1). When explaining "rebellious defiance", Aggerholm (2020, 11) says:

> Here, the object of defiance is a condition of dominant and suppressive authority that appears unjust, unfair or irrational to the athlete confronted with it. The defiant acts can be directed at governing bodies of sport that neglect or support unjust social oppression and unequal treatment of athletes. It can also be directed at particular individuals, such as coaches, who exaggerate their authority or in other ways act in unjustified ways.

Hence, "rebellious defiance" towards authority, such as governing bodies and coaches, fits how I use defiance in "unruly behaviour". Defiance in this sense is also linked with the other elements of "unruly behaviour" such as being disobedient, which may involve being argumentative and disruptive.

Aggerholm offers an example of good rebellious defiance from outside sport. He says that "A classic case of such virtuous defiance was when the black woman, Rosa Parks, in 1955 defied racial segregation rules in Alabama by refusing to give up her seat to a white passenger on a bus" (Aggerholm 2020, 11). He says that when "athletes stand up for themselves or show solidarity with others who face injustice" this is virtuous (Aggerholm 2020, 13). He offers examples from sport that may be considered praiseworthy, such as kneeling against racial inequality and female athletes refusing to accept being paid less than males (Aggerholm 2020, 12-13). Hence, there are some good reasons to be defiant in sport.

Summary

The work of Potter and Aggerholm offers examples of when there are good reasons to be defiant. We do not need to accept Potter and Aggerholm's claims about defiance being a virtue, but they do give reasons to think that defiance, which is captured by the term "unruly behaviour", produces goods for those across the age groups. Unlike the characteristic youth behaviour of NSSH, unruly behaviour produces goods for children, youth and adults.

A character trait

Unlike NSSH, which is a behaviour, unruliness may be a character trait or state. "Character traits" provide the structure of personality. If someone has the disposition of unruliness in many situations and reacts consistently in an unruly way then the unruliness is a "character trait". On the other hand, a "state" of unruliness is a passing disposition that does not become embedded into one's personality. A state of unruliness may be displayed by children, youth and adults. A question, then, for managing unruliness is whether unruly behaviour should be encouraged as either a state or character trait.

On being a character trait, this is what Potter (2016, 77) says when discussing becoming "dispositionally defiant":

> Traits are thought to comprise the basic structure of personality (Pervin 1994). A trait suggests an enduring tendency to react to many situations in a consistent manner, whereas a state suggests a temporary or passing behavior or emotional response (Endler and Kocovski 2001; Pervin 1994). A state can also refer to a set of symptoms that appears but may abate fairly quickly (Reich 2007). States can pass into traits just as, in virtue theory, repeated actions can develop into virtues or vices over time.

I should emphasise that I use having a "disposition" in a different way to Potter. I say that "unruliness" is having a disposition to display "unruly behaviour". That disposition may be a state or a trait.

The need for encouragement

I am not able to picture a case in which someone would be encouraged to engage in NSSH. However, there are cases when it is beneficial for an individual to encourage having a disposition to display unruly behaviour.

To illustrate the benefit of unruliness, consider an example in which a lack of unruliness has a negative impact on an individual's welfare. Tom is an adult who has never been unruly. He was a very obedient boy growing up. He never challenged his parents even when he questioned to himself some of the things he was told or asked to do. Tom played sports, despite not finding them enjoyable, because this was what his father wanted. His parents decided on the subjects he studied at school and what career path he took. Tom enjoyed music and art at school; however, his parents did not think these subjects would amount to any career, so Tom did not pursue them. Instead, Tom studied law at university. He took an interest in family law, but his father advised him to follow him into the more lucrative area of corporate law. Tom spent his entire working life in the corporate law firm his father set up; yet, that is not where his passion lay.

Tom grew up being taught, by his parents, to be obedient. He was not able to pursue the things that brought him pleasure like music and art. Decisions at school and with his career were made for him. From the example it is not clear what impact there was on family life and friendships for Tom. However, one may imagine that Tom's relationship with his parents is perhaps strained. Furthermore, as Tom is not pursuing the activities and career that he wants he is not likely to be surrounded by likeminded people. This may have impacted on the number or type of friends Tom had growing up and on the friendships he has now. I am not able to comment with certainty on what things would have had a positive impact on Tom's welfare, but I am able to confidently say that many people care about their

relationships, a form of work that brings satisfaction and engaging in pleasurable activities. Obediently following his parents' orders has impeded on Tom's relationships, work and activities.

To put it another way, a lack of unruliness has had a negative impact on Tom's welfare. However, if Tom was encouraged to be unruly his welfare may not have been negatively impacted. Tom's life would have been different had he learned the benefit of when and how to not follow requests and orders from authority figures, such as his parents. Also, if he discovered how to rebel, and be argumentative, disobedient, defiant or disruptive he may have pursued the goals he wanted, and his welfare may have been positively affected.

To provide another illustration of the benefit of unruliness, consider the first-person narrative of a "victim/survivor" of sexual abuse (Kingi et al. 2009, 80). This narrative is about the pressure the individual faced from others to withdraw their complaint:

> There was pressure from my family, extended family, and general public. [The perpetrator] broke my name suppression so the general public actually knew about it and I went down to the court a couple of times because I needed to put some demons to rest and I got pressured from the public about how cruel I'd been. How cruel I was being to this poor gentle old man and how he's such a respected and amazing man, he's a true gentleman in all sense of the words, rah, rah, rah. It just made me more defiant if nothing else. It was pressure that made me more defiant to show them that this is another side to this man that they know nothing about and that I'm sick of for 25 years having my credibility and integrity questioned. My integrity and my credibility are all I have. I'm not about to have it assassinated. I'm surprised I didn't tell them to 'fuck off' actually (Kingi et al. 2009, 80).[67]

[67] I have made a slight amendment to the quote to correct the grammar.

In this narrative, it seems that having the ability to be defiant and disobedient helped this individual progress with the criminal proceedings against the perpetrator. I am offering the idea, then, that encouraging others in similar circumstances to refuse to follow requests, rebel, and be disobedient and defiant may be helpful.

Hence, unlike the characteristic youth behaviour of NSSH, sometimes unruliness may advance an individual's welfare.

The "never a mental disorder" view

There are some who say that unruliness in children and youth does not constitute a mental disorder in its own right. [68] For example, I have observed that some clinicians do not view the unruliness seen in ODD and conduct disorder to be mental disorders. To illustrate that others observe this as well, consider an editorial for a special journal issue on conduct problems titled '*Do clinical services need to take conduct disorder more seriously*?' (Coghill 2013). The editorial is written by David Coghill, a child and adolescent psychiatrist. Coghill (2013, 922) says that children and youth with ODD and conduct disorder are often rejected by specialist, secondary mental health services at the referral stage or at an initial screening assessment.[69] He says this is likely due to the assumption that unruliness seen in ODD and

[68] Some may say that unruly behaviour may be a symptom of a mental disorder. For example, someone with depression may be argumentative and someone with anxiety may be disruptive to avoid anxiety-provoking situations. In these cases, unruly behaviour is evidence of a mental disorder. Yet, unruly behaviour, in its own right, does not constitute a mental disorder.

[69] In Coghill's editorial (2013, 922) he observes that the request for help with managing the unruly behaviour seen in ODD and conduct disorder is often rejected by specialist, secondary

conduct disorder is viewed as bad behaviour or due to poor parenting rather than mental disorders (Coghill 2013, 922).[70]

Coghill (2013, 922) says that there are three reasons why unruly behaviour seen in ODD and conduct disorder is not viewed, by some clinicians, to be a mental disorder. The first is that they think unruly behaviour is bad behaviour rather than a mental disorder. The second is that they think unruly behaviour is due to poor parenting rather than a mental disorder. The third reason is a combination of both the first and second reasons. Many will intertwine the two points and say that unruly behaviour is bad behaviour due to poor parenting rather than a mental disorder. To illustrate the view that unruliness is bad behaviour due to poor parenting and not a mental disorder, consider the following public comments.

The first comment is from an online news article. The article leads with the title '*Defiant toddlers are being branded mentally unwell, NHS report finds*' (Bodkin 2018). The article also discusses older children. "NHS" is an acronym for the "National Health Service"

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mental health services and, instead, non-health community services are recommended. This is my observation as well.

[70] It is interesting to note that Coghill (2013, 922) is of the view that not all children and youth who display behaviours seen in ODD and conduct disorder require specialist, secondary mental health services. Yet, he does say that there is growing evidence that ODD and conduct disorder are "neurodevelopmental disorders, with biological underpinnings and serious long-term outcomes", so they should be treated more seriously by mental health clinicians and policy makers (Coghill 2013, 922). I assume here that "biological underpinnings" means physiological process or structures in the brain. This implies that he thinks unruly behaviour needs to be viewed as a kind of disorder to warrant, in some cases, an intervention from specialist, secondary mental health services.

in the United Kingdom. The report the article refers to is a survey of the mental health of children. The article says the report is being "criticised by experts for inappropriately 'medicalising' unruly behaviour. Based on information from 9,117 children and young people health chiefs say 5.5 per cent of preschool children now have a mental health disorder" (Bodkin 2018, para. 4). Attached to the news article are public comments. One theme of comments is that unruly behaviour is being falsely classed as a mental disorder when it is due to poor parenting. One commenter says "So kids who have 'parents' who are unwilling to instil basic discipline and social skills into them before any sort of formal schooling have a 'psychological problem' instead of, basically, being spoiled little brats whose parents have failed them spectacularly?" (Bodkin 2018, '*Linux Roach 23 November 2018 6:56 pm*'). The inclusion of "spoiled brats" implies that there is bad behaviour on the part of the child, and saying children are being parented by those who have "failed them" implies that they are experiencing poor parenting.

Here is another comment to illustrate the view that unruliness is bad behaviour due to poor parenting and not a mental disorder. This comment is attached to an online news article titled '*Children with problems or problem children?*' (Richardson 2018). The article discusses the idea that unruly behaviour seen in children may be a sign that there is something wrong with the mental health of the child (Richardson 2018).[71] The article also mentions conduct disorder when there are "Severe and persistent behavioural problems" (Richardson 2018, para. 30). One comment in response to the article says "Bad behaviour is not just bad behaviour anymore – it's always a 'disorder'. Being naughty is not a disability. It's just lazy parenting. Stop making excuses for your badly behaved kids. Install some

[71] My interest here is the question of whether unruly behaviour is a mental disorder in its own right, not of whether unruly behaviour is a symptom of a mental disorder.

discipline in their lives" (Richardson 2018, '*123. Carol Katrawitz 20 Oct 2018 00:37*').[72] This comment explicitly refers to the behaviour as "bad behaviour" and the child as "naughty" due to "lazy parenting".

Coghill's observations and the public comments illustrate the "never a mental disorder" theory. These examples illustrate the view that unruly behaviour is not a mental disorder in its own right and that it is, instead, bad behaviour due to poor parenting. The second part of the view may be replaced with other statements. For example, it might be said that unruly behaviour is not a mental disorder in its own right and, instead, unruly behaviour is bad behaviour due to a lack of physical discipline in schools. Another possible claim is that unruly behaviour is bad behaviour due to playing violent computer games. There are many more statements that may be made. What this theory says is that unruly behaviour is not a mental disorder in its own right, so it is not a matter for mental health services. Instead, the behaviour would be resolved if children and youth had better parents, were physically disciplined in schools or did not play violent computer games.

The "never a mental disorder" theory is different to my claim. In chapter two, I argued that NSSH in youth is never a mental disorder in its own right. Yet, NSSH needs to be managed, even if it is not a mental disorder. At times, that management involves interventions offered by specialist, secondary mental health services. Also, in chapter two (pp. 71-73), I have said that sometimes someone who *does not* have a mental disorder *does* require funded mental health treatment and that sometimes someone who *does* have a mental disorder *does not* require funded mental health treatment. To illustrate the possibility that someone does not have a mental disorder and requires treatment I offered the case of someone feeling depressed. Her depressed state was due to breaking up with her girlfriend.

[72] I have made a slight amendment to the quote to correct the spelling.

Her state worsens due to a lack of support from the homophobic society she lives in. In this hypothetical case she does require an intervention from a specialist, secondary mental health service to address the depressive state. Also, she requires an intervention that will change the prejudices she faces, so she also requires an intervention that is directed at the situation, but she does not have a disorder. In this chapter, I have pointed out that unruly behaviour may, perhaps, be a disorder or not. Unruly behaviour in children and youth sometimes needs to be managed, even if it is not a mental disorder. At times, that management involves interventions offered by specialist, secondary mental health services. My claim, then, is that having a mental disorder is not necessary for warranting interventions from a specialist, secondary mental health service.

The "never a mental disorder" theory, which says that the phenomenon is not a mental disorder in its own right, so it is not a matter for mental health services, is mistaken. To show that some children and youth who display unruly behaviour warrant an intervention, even if unruly behaviour is not a mental disorder, consider a corresponding explanation from the "never a mental disorder" theory. The explanation is that unruly behaviour is bad behaviour due to poor parenting. Even if this statement is accurate, the explanation oversimplifies the situation. When a child or youth is experiencing poor parenting, it may be because the parent had problematic parenting role models or they are having to deal with pressures, such as enduring abuse alongside trying to parent. Also, a child or youth may experience poor parenting due to them or their parent being ill. For instance, it is difficult for a parent to instil discipline and social skills when their child is having long stays in hospital. There are many more reasons why a child or youth may experience poor parenting.[73]

[73] For example, parents may forget to pick up the parenting manual that is handed out to all new parents.

The simplified statement that unruly behaviour is due to poor parenting does not tell us much about any need for intervention. For example, a child whose parent is having to deal with pressures, such as enduring abuse alongside trying to parent, may only need an intervention that is directed at the situation. The child may only need the parent to no longer experience abuse. On the other hand, a child who missed out on developing certain social skills due to a long stay in hospital may need an intervention from a specialist, mental health service. It may also be the case that a child experiencing poor parenting requires both interventions. For instance, consider a child experiencing poor parenting due to having abusive parents. In this case an intervention is needed from a child protection service to ensure the child is not abused, and the child may need an intervention from a specialist, secondary mental health service because they have not learnt the skills needed from their parents.

Lastly, a child who is being unruly due to poor parenting may require no intervention. For instance, a parent may struggle when alone, resulting in poor parenting. They are often alone because their partner is regularly away, for example, due to work or visiting family. In this situation no intervention is required because the unruly behaviour stops when the child has video-conferencing contact with the parent who is away, the parent still at home adapts to coping in the situation or the child grows out of the behaviour. Hence, even if accurate, simplified statements, like the suggestion that unruly behaviour is bad behaviour due to poor parenting, do not tell us much and do not imply that interventions from a specialist, secondary mental health service are not warranted.

It is also worth noting that it is impossible to capture all the causes of unruly behaviour in a single simple statement. It is not the case that all unruly behaviour is solely due to circumstances like poor parenting or playing violent computer games. There are some who parent well but have children who are unruly for other reasons. Furthermore,

there are some children and youth who are unruly and have never played violent computer games. Plus, there are children and youth who often play violent computer games but are not unruly.

Lastly, simple explanations may be harmful. I have two worries. The first worry is that such explanations do not take into consideration individual needs. For instance, if the view is that unruly behaviour is due to playing violent computer games, then I worry that adults will assume that stopping their child from playing these games is the most effective intervention, if an intervention is needed. Yet, this may not be the best intervention for their child. My second worry is that a simple explanation may create stigma that prevents those needing support from accessing it. For example, saying unruly behaviour is due to poor parenting may make parents feel at fault for their child's behaviour. This may lead to parents being reluctant to seek out support or help because they think they will be blamed. This means that simple explanations do not tell us much; do not lead to saying interventions from a specialist, secondary mental health service are not warranted; and may cause harm.

Conclusion

By comparing the case of unruliness with NSSH, I have identified some distinguishing features that make it an interesting case to use in this dissertation. In some cases, unruliness in its own right meets the diagnostic criteria for a mental disorder. Furthermore, the research suggests that many children and youth who are diagnosed with ODD and conduct disorder are likely to persist with unruly behaviour into adulthood. Someone may, then, say that this is evidence that we should offer interventions from a specialist, secondary mental health service. On the other hand, unruly behaviour may also be part of a passing phase and produce goods of childhood and adolescence. Furthermore, in some cases, unruly behaviour may be praiseworthy, and encouraging unruliness may advance

an individual's welfare. All these observations about unruly behaviour make it difficult to decide whether a child or youth who is being unruly should be offered interventions from a specialist, secondary mental health service. Over the next two chapters I discuss this decision.

Furthermore, in the next chapter, I ask the question: who should be offered interventions from a specialist, secondary mental health service? I aim to challenge the assumption that acts as a prominent answer ─ "those with mental disorders". In this dissertation, I have already claimed that having a mental disorder is not necessary for warranting interventions from a specialist, secondary mental health service. In the next chapter, I will show that having a mental disorder is not sufficient either. By making this argument I will disrupt further the relationship between having a mental disorder and warranting an intervention from a specialist, secondary mental health service.

Chapter five: unruly behaviour, non-suicidal self-harm and intervention[74]

Introduction

Consider the composite case of a clinician working in a specialist, secondary mental health service. She works with children and youth who have been diagnosed with mental disorders. She has a desk in an open-plan office on the second floor where she sits with her colleagues. On the floor below are rooms containing comfortable chairs, bean bags, toys and coffee tables each with a box of tissues. On the ground floor, there is a reception area with magazines and a bright mural on one wall painted by some of the children who use the service. The other walls have a block colour of either blue, green or white because it is thought these colours create a sense of calm.

She is sitting at her desk replying to emails and eating her lunch when her telephone rings. The receptionist tells her that Tina is on the telephone crying. Tina is the mother of a 7-year-old female she is working with. Tina is distressed because her husband has been told by the police to stay away from the family home while the local child protection team investigates. Her daughter, April, called the police last night alleging her father physically assaulted her. Tina explains that her husband was trying to restrain April who was repeatedly kicking towards Tina's head. Tina asks why it is that her daughter is allowed to shout at them daily and now physically hit them.

Now consider another working day for the clinician. This time when she answers the telephone to one of the receptionists she notices panic in her voice. The receptionist asks the clinician to come to reception urgently. The police have been called, but she needs help

[74] In parts of this chapter I use my paper, which is under submission with a social work journal.

because Luke is in reception with a 9-inch chef's knife. Luke is a 15-year-old male.[75] He often threatens other people and has been known to start physical fights. On one occasion at school he broke a window by throwing chairs. He has attacked someone with a knife before too.

The composite cases of Tina's daughter April and Luke are examples of the kinds of unruliness that a clinician working in a specialist, secondary mental health service encounters.

The question and preview

In this chapter, I ask the question: who should be offered interventions from a specialist, secondary mental health service?[76] I use the cases of unruly behaviour and non-suicidal self-harm (hereafter referred to as "NSSH") to suggest that on *any* plausible theory or definition of disorder, it is not the case that all those with mental disorders should always be offered interventions from a specialist, secondary mental health service. The aim is to show that the relationship between having a mental disorder and warranting an intervention is weak.

I discuss four views. The first view is this: those who meet diagnostic criteria, so have a mental disorder, should be offered interventions from a specialist, secondary mental health service. I refer to the first view as the "diagnostic criteria" view. The second view is this: those who have an internal dysfunction, so have a mental disorder, should be offered interventions from a specialist, secondary mental health service. The second view is referred to as the "internal dysfunction" view. The third view is this: those who meet the "scientistic

[75] Luke has already been briefly presented in the introduction.

[76] I remind the reader that this question is the question of when it is good to offer interventions (see p. 7 where I explain this further).

definition" of disorder should be offered interventions from a specialist, secondary mental health service. The third view is referred to as the "scientistic definition" view. The fourth view is this: those who meet the "social constructionist definition" of disorder should be offered interventions from a specialist, secondary mental health service. The fourth view is referred to as the "social constructionist definition" view.

In the discussion, it is not necessary for me to make a claim about whether I accept any of these theories or definitions of disorder. It is not necessary for me to make a claim about whether I accept these views of disorder because I am using them as evidence to suggest that on *any* plausible theory or definition of disorder, it is not the case that all those with mental disorders should always be offered interventions from a specialist, secondary mental health service. Instead, I use the case of unruly behaviour and NSSH to show that having a mental disorder is not sufficient for warranting interventions from these services. My claim is a new addition to the philosophical discussion about the nature of mental disorder.

I start with the diagnostic criteria view.

The "diagnostic criteria" view

The composite cases of April and Luke are examples of unruly behaviour that meet the diagnostic criteria for having mental disorders. April has a diagnosis of "oppositional defiant disorder". Luke has a diagnosis of "conduct disorder". The latest versions of the '*International Classification of Diseases*' (ICD-11) and the '*Diagnostic and Statistical Manual*' (DSM-5) both contain "oppositional defiant disorder" (hereafter referred to as

"ODD") and "conduct disorder".[77] [78] According to the diagnostic criteria view, if a child or youth's unruliness meets the diagnostic criteria for ODD or conduct disorder then the child or youth has a mental disorder, and the child or youth merits intervention; otherwise, she does not.

The dual diagnosis of oppositional defiant disorder and conduct disorder

The composite cases of April and Luke illustrate separate cases of ODD and conduct disorder. ODD and conduct disorder are distinct disorders so someone may be diagnosed with both disorders.

Previously ODD was not diagnosed in those who already had a diagnosis of conduct disorder (for a discussion on this point see Fairchild et al. 2019, 3, and Ghosh, Ray, and Basu 2017, 354-355). ODD generally occurs before someone meets the diagnostic criteria for conduct disorder; however, many diagnosed with conduct disorder have never met the criteria for ODD but someone with conduct disorder is at a higher risk of having ODD (for a summary see Fairchild et al. 2019, 2-3, and Ghosh, Ray, and Basu 2017, 355). As an example of someone who meets the diagnostic criteria for both ODD and conduct disorder, consider the composite case of Jane.

Jane is a 7-year-old female. Her parents describe her as "always being headstrong"; yet, for the last year they have become concerned about her behaviour. She has daily arguments with her parents and refuses to follow their requests. Sometimes she "coldly," tells her parents she "hates" them and wishes they "were dead". At school, she "teases" younger

[77] The ICD-11 (World Health Organization 2019, section 6C91) refers to conduct disorder as "conduct-dissocial disorder".

[78] For a summary of ODD and conduct disorder and further details see chapter four (pp. 95-98) and refer to appendix two for detailed diagnostic criteria.

children, blames others when she has caused verbal fights and often falls out with her peers for, sometimes, no reason. Jane meets the diagnostic criteria for ODD.

Now consider Jane at the age of 14 years old. She meets the diagnostic criteria for ODD and conduct disorder. Her parents describe her behaviour as still "cold" and now "out of control" having progressively gotten worse. Jane has hit both parents in separate incidents and on one occasion she destroyed the family's music system with a bat. Jane has rarely been at school for the last 6 months. Her teacher states that, when she was regularly attending school, she would often get into trouble for bullying her peers. Jane has been caught on one occasion stealing money from a teacher's bag. They suspect that there have been other occasions too.

April, Luke and Jane meet the diagnostic criteria for ODD, conduct disorder or both. According to the diagnostic criteria view, in each case their unruliness constitutes a mental disorder because diagnostic criteria are met.

Does meeting diagnostic criteria determine who should be offered interventions from a specialist, secondary mental health service?

I now ask: does meeting diagnostic criteria determine who should be offered interventions from a specialist, secondary mental health service? To make my point, consider the following cases that show that sometimes someone who meets the diagnostic criteria *does* warrant an intervention and sometimes *does not* warrant an intervention.

When meeting the diagnostic criteria does warrant an intervention from a specialist, secondary mental health service

April, Luke and Jane all meet the diagnostic criteria and warrant interventions from a specialist, secondary mental health service. All three require an intervention because of the high likelihood of negative outcomes they face due to their unruliness.

I first draw upon the research to describe the negative outcomes of ODD for the individual. Children and youth diagnosed with ODD have frequent conflicts with people that, according to the DSM-5 (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*'), often result in "significant impairments in the individual's emotional, social, academic, and occupational adjustment". Research suggests that the negative outcomes of ODD include continued ODD, and an increased risk of developing disorders such as depression, anxiety and conduct disorder (Ghosh, Ray, and Basu 2017, 355). There are very few studies on the negative outcomes of ODD when it continues into adulthood or when someone who has had ODD in the past becomes an adult. The research that has been done with older youth does indicate it is likely that problems with relationships, such as with peers, family members and romantic relationships, will persist into adulthood (Burke, Rowe and Boylan 2014, 265 and 271).

Now, I describe the negative outcomes of conduct disorder for the individual. Children diagnosed with conduct disorder are frequently excluded from school and experience rejection by their peers due to their behaviour (Fairchild et al. 2019, 16). Research suggests that the negative outcomes of conduct disorder include continued conduct disorder and developing disorders, such as depression, anxiety, substance-use, and antisocial or borderline personality disorder (Fairchild et al. 2019, 16-18). Also, negative outcomes include serious criminal behaviour, gang involvement, homelessness, having a lower education standard, suicidality, cardiovascular problems and early mortality in adulthood (Fairchild et al. 2019, 16-18).

There is, then, a high likelihood of many negative outcomes for the individual. There are also many negative outcomes for other people. For example, siblings may not receive the attention they need from their parents because their brother or sister's behaviour is a burden. Also, another potential negative outcome for others is parents being ostracised due to their

child's behaviour. Plus, family, friends, teachers, colleagues and the public may face negative outcomes, such as having their property damaged, and being physically assaulted and verbally abused. There is also an economic cost to society. The economic cost to society is due to the need for resources to manage ODD and conduct disorder. The resources mainly come from the health, social welfare, education and the criminal justice sectors.

By focusing only on the negative outcomes for the individual I do not wish to say that others do not face negative outcomes. The reason why I only focus on the negative outcomes for the individual is that I am determining whether April, Luke and Jane require an intervention.

There are many interventions that specialist, secondary mental health services are equipped to offer that may be helpful for April, Luke and Jane. The United Kingdom National Institute for Health and Care Excellence (hereafter referred to as "NICE") (2017) provides updated guidelines for the prevention and management of ODD and conduct disorder.[79] [80] For children and youth aged between 3 and 11 years old who meet the criteria for ODD or conduct disorder, the recommendation is a parenting or foster carer training programme to develop parenting skills to help lessen the unruly behaviour. For those aged between 9 and 14 years old who meet the criteria for ODD or conduct disorder, the recommendation is a group programme for the child or youth that has a focus on developing problem-solving skills. For those between the age of 11 and 17 years old who meet the criteria for conduct disorder, the recommendation is an intervention such as multisystemic

[79] The United Kingdom National Institute for Health and Care Excellence used to be named the "National Institute for Clinical Excellence". For ease I use "NICE" to refer to both.

[80] See section 1.5 and 1.6 for the recommendations of the management of ODD and conduct disorder (NICE 2017).

therapy. Multisystemic therapy is an intensive therapy of two to three sessions each week with the parents or carers for several months. There is usually 24-hour telephone support alongside the sessions. The NICE (2017, section 1.6) also say that a short-term pharmacological intervention may be considered in certain cases. From my clinical experience, April, Luke and Jane may also benefit from other interventions, like family therapy and individual therapy.

April, Luke and Jane meet the diagnostic criteria for ODD, conduct disorder or both. According to the diagnostic criteria view, if a child or youth's unruliness meets the diagnostic criteria for ODD or conduct disorder then the child or youth has a mental disorder, and the child or youth merits intervention.

On my view, April, Luke and Jane each warrant an intervention from a specialist, secondary mental health service. Although on my view having a diagnosable mental disorder is not why they warrant an intervention, all three require an intervention because of the high likelihood of negative outcomes they face due to their unruliness.

When meeting the diagnostic criteria does not warrant an intervention from a specialist, secondary mental health service

To illustrate a case of unruliness that meets the diagnostic criteria and does not warrant an intervention from a specialist, secondary mental health service, consider the hypothetical case of Annie. Annie is a 15-year-old female. Annie meets the ICD-11 and DSM-5 diagnostic criteria for both ODD and conduct disorder. She meets the diagnostic criteria for ODD because she has been displaying frequent defiant and disobedient behaviour for over 6 months. She has been spiteful, at least twice, within the past 6 months too. She is often angry and resentful, and often argues with those in authority and defies their requests. The behaviour is not directed to a sibling and there is a significant impairment in important areas of her life. Annie also meets the diagnostic criteria for conduct disorder because she has

been violating major societal norms, rules and laws for the past year and she has no plans to stop her behaviour. She is often threatening and she has used a brick as a weapon. Also, she has broken into cars and stolen items. Annie's unruly behaviour is having a negative impact on many areas of her life, such as her relationship with her parents and her peer relationships.

Despite the unruliness seen in Annie's case, she does not warrant an intervention from a specialist, secondary mental health service. This is because Annie lives in an environment in which the societal norms are unjust and her unruliness is a response to those unjust norms. Annie lives in a society where females over the age of 14 years old are not legally allowed to continue gaining an education; instead, the societal norm is to gain employment.[81]

Here are the further details of Annie's case. She has been disobeying her parents for the past year. She refuses to follow their rules, so she avoids doing chores at home, she comes home past the time she is told and she refuses to go to work. Instead, Annie has been going to school. There have been many times police officers have forcefully removed Annie from school and she has become verbally aggressive and threatening towards them. She also scratched a police car when officers tried to force her into the car. She wants money for schoolbooks, so she breaks into cars with her friends to steal items, such as loose change, coats and mobile phones. Annie has a spiteful exchange on social media with government officials who are trying to stop her from encouraging other females to stay at school. She is often angry and resentful towards those who are allowed to attend school. She gets into verbal fights with other young people, who do not like her attending school, and sometimes

[81] The reader may read the hypothetical case and note some similarities with well-known activists; yet, I am not saying an actual individual meets the diagnostic criteria. This is a hypothetical case.

these fights become physically violent. During one physical fight she used a brick and seriously hurt another young person.

Annie's unruliness is understandable. Her anger is directed towards the police, who remove her from school, and government officials, who are trying to stop her from encouraging other females to stay at school. Furthermore, her anger is directed towards those who are allowed to attend school and those who do not like her attending school. Her anger is understandable due to the injustice of being deprived of an education just because she is female. Annie's unruliness is directed towards her desire to continue to gain an education and to allow all females to continue their education, if they want to. She disobeys her parents, the police and government officials due to this desire. She also breaks into cars and steals items to allow her to gain money to continue to gain an education. Her desire to gain an education is understandable because, generally, gaining an education is done to develop important skills and knowledge. For Annie gaining an education will fulfil her inquisitiveness about many aspects of the world. This appears to be an understandable desire for Annie to have; however, she is being prevented from obtaining her goal due to an unjust society.

Annie meets the diagnostic criteria for ODD and conduct disorder. According to the diagnostic criteria view, meeting diagnostic criteria means her unruliness constitutes a mental disorder. However, Annie does not require an intervention from a specialist, secondary mental health service. Instead, Annie requires an intervention that will change the unjust society she lives in; she requires an intervention directed at a wider change of the social circumstances, which is not offered by specialist, secondary mental health services.

I now present the internal dysfunction view.

The "internal dysfunction" view

To illustrate the internal dysfunction view, consider a study undertaken by academics with clinical experience, Jerome C. Wakefield, Kathleen J. Pottick and Stuart A. Kirk (2002). The study asked psychology and social work graduate students with clinical experience to read vignettes and then rate their level of agreement about whether the youth in the vignettes had a mental disorder, needed professional help, and whether the concerning behaviour that is detailed would likely continue into adulthood (Wakefield, Pottick and Kirk 2002, 383). The authors' hypothesis was that the research participants would say that an internal dysfunction is necessary for a mental disorder (Wakefield, Pottick and Kirk 2002, 382). [82]

The authors define internal dysfunction's conditions as:

> conditions in which something has gone wrong with the functioning of some internal psychological mechanism or structure. It does not refer to maladaptive behavior per se; one can behave maladaptively in various circumstances (e.g., in one's marriage or at work because of boredom) without having an internal dysfunction or disorder (Wakefield, Pottick and Kirk 2002, 381).

This means that, in their paper, an "internal dysfunction" is a failure of an internal psychological mechanism or structure.[83] The authors say that the unruly behaviour seen in

[82] The authors say that having an "internal dysfunction" is "an intuitive concept of disorder that underlies medical judgments and is widely shared by health professionals" (Wakefield, Pottick and Kirk 2002, 380). As a clinician, I am not committing to this view. Agreeing or disagreeing with this theory is not of importance for my claim.

[83] Wakefield's (1992, 374) well-known definition of mental disorder is that a necessary condition is dysfunction, which "is a scientific and factual term based in evolutionary biology that refers to the failure of an internal mechanism to perform a natural function for which it

conduct disorder may be a dysfunction in "mechanisms involved in the capacity for empathy, guilt, moral conscience, and impulse control" (Wakefield, Pottick and Kirk 2002, 381). They also point out that an internal dysfunction may be caused by a negative environment; however, if someone is reacting to a negative environment without an internal dysfunction then she does not have a mental disorder (Wakefield, Pottick and Kirk 2002, 381).

In the study, the participants were given case vignettes of unruly behaviour that met the diagnostic criteria for conduct disorder.[84] The vignettes were adapted in an attempt to show that either the unruly behaviour was a reaction to a negative environment or an internal dysfunction was causing their behaviour (Wakefield, Pottick and Kirk 2002, 383). [85] For example, one case vignette was written about the hypothetical case of "Carlos" (Wakefield, Pottick and Kirk 2002, 383).

Carlos is a young person. He often bullies his peers, initiates fights and truants from school. He has also used a bat as a weapon in a fight. His behaviour impacts seriously on his relationships. One adapted case attempts to say that Carlos's unruly behaviour is a reaction to a negative environment. He is living in a neighbourhood that is heavily influenced by gangs

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was designed". This condition is not explicitly mentioned in the paper when describing an "internal dysfunction".

[84] This study was done when the DSM-IV diagnostic criteria was in use. The use of previous criteria is not of importance because I am discussing the participants' view that an internal dysfunction constitutes a mental disorder, not whether they think someone meets diagnostic criteria. Also, the participants were not asked if the unruly behaviour met the diagnostic criteria (Wakefield, Pottick and Kirk 2002, 383).

[85] There is no means of testing for an internal dysfunction.

and he has joined a gang for protection. The second adapted case says that Carlos's unruly behaviour is disproportionate to the threats, his behaviour is directed to members of opposing gangs and his own gang, and when he spent several months in more non-threatening surroundings his behaviour continued. This vignette was written in this way in an attempt to say that Carlos's unruly behaviour is due to an internal dysfunction.

The results of the study supported the authors' prediction. Most of the participants in the study said that the hypothetical cases that were written to illustrate an internal dysfunction were examples of mental disorders (Wakefield, Pottick and Kirk 2002, 383-384). Furthermore, very few participants thought that the cases that illustrated a reaction to a negative environment were examples of mental disorders (Wakefield, Pottick and Kirk 2002, 383-384). This means the participants are of the view that having an internal dysfunction, and not reacting to a negative environment, constitutes a mental disorder.

Does having an internal dysfunction determine who should be offered interventions from a specialist, secondary mental health service?

I now discuss the question: does having an internal dysfunction determine who should be offered interventions from a specialist, secondary mental health service?

To answer the question, keep considering the study by Wakefield and colleagues (2002). Most of the research participants thought that all the case vignettes of unruly behaviour described situations that warranted intervention (Wakefield, Pottick and Kirk 2002, 384). This means that even the cases that, according to the internal dysfunction view, do not constitute a mental disorder were judged to warrant an intervention.

Yet, it is not clear whether the participants thought an intervention from a specialist, secondary mental health service was warranted. The participants were asked to rate their

agreement on the following statement: “This youth needs some kind of professional mental health help” (Wakefield, Pottick and Kirk 2002, 383). It is safe to assume that many of the participants would say that an intervention from a specialist, secondary mental health service is a “professional mental health” intervention. From my clinical experience, an intervention from a specialist, secondary mental health service is the kind of intervention mental health clinicians offer. An intervention directed at wider changes in social circumstances is usually offered by social welfare agencies.

The participants’ viewing all cases as warranting intervention may mean several things. It may be the case that, in their view, having an internal dysfunction is not necessary for an intervention from a specialist, secondary mental health service to be warranted. It may mean that, in their view, having an internal dysfunction is neither necessary nor sufficient for an intervention from these services to be warranted. On the other hand, it may mean that, in their view, having an internal dysfunction is sufficient for an intervention from a specialist, secondary mental health service to be warranted; however, the clinicians are unsure when someone has an internal dysfunction, so they think it is best to offer an intervention from a specialist, secondary mental health service in all cases.

Internal dysfunctions versus reactions to the environment

There is recognition by the authors of the study that distinguishing between internal dysfunctions and reactions to the environment is not always possible in practice.[86] The authors say:

[86] I think it is *never possible* in practice rather than it being *not always possible* due to the cases I will present. However, the points I make in this section will still stand with the statement that it “is not always possible”.

> many of the same problematic environments—e.g., threatening, impoverished, high crime—that can cause genuine dysfunction and disorder can also cause nondisordered children to react with antisocial behavior. For example, deprived environments may cause enduring biological dysfunctions in empathy or impulse control that lead to antisocial behaviors, but the same environments may also cause psychiatrically normal youths to reasonably choose to act in socially undesirable ways out of motives of self-protection or social conformity (Wakefield, Pottick and Kirk 2002, 381).

This means that determining whether unruly behaviour is a reaction to the environment, an internal dysfunction or both is not always practically possible.

To add a further point, consider again the hypothetical case of Carlos used in the study (Wakefield, Pottick and Kirk 2002, 383). In the first adapted case that says Carlos's unruly behaviour is due to the environment, he is living in a neighbourhood that is heavily influenced by gangs and he has joined a gang for protection. This case was written in an attempt to say that Carlos does not have an internal dysfunction. Yet, Carlos's behaviour may be a case of an internal dysfunction, whatever an internal dysfunction may be. Consider my addition to the hypothetical case of Carlos.

In my addition, let us still imagine there is agreement on the function of many mental states. Now imagine Carlos has an internal dysfunction in empathy and impulse control. As a result of the internal dysfunction, he seeks out environments that meet his internal need to behave in an impulsive and unempathetic manner. In this case he seeks out the gangs in his neighbourhood. He says he has joined a gang for protection, which is accurate. Initially, Carlos behaved in an impulsive and unempathetic manner on his own, which resulted in retaliation from the gangs in his neighbourhood. He joined a gang for protection from this retaliation. The benefit of joining the gang also meant he is still able to behave in an

impulsive and unempathetic manner. This means that it appears Carlos is reacting to the environment when he has an internal dysfunction.

To illustrate further how distinguishing between internal dysfunctions and reactions to the environment is not always possible in practice, consider the composite case of April. April is the case I presented at the beginning of the chapter. She is a 7-year-old female who has called the police alleging her father physically assaulted her. However, her mother, Tina, says that her husband was not physically assaulting April, but he was trying to restrain her because she was repeatedly kicking towards Tina's head. April often gets angry with her parents, but it is rare that she has physically hurt them. April argues daily with her parents and refuses to follow their requests. Her unruly behaviour, which has been occurring since she was a toddler, is having a negative impact on her relationship with her parents.

From my clinical experience, in this case April's unruly behaviour is more likely to be seen as a reaction to a negative home environment. This is because the behaviour is only happening in one setting. April's unruly behaviour is confined to her home. When the unruly behaviour is only seen in one setting, some clinicians view the unruly behaviour to be a reaction to a negative environment rather than some kind of internal dysfunction, whatever an internal dysfunction may be. This is because they assume that an internal dysfunction would result in unruly behaviour in multiple areas. For example, if April has an internal dysfunction, such as with her impulse control, then it is assumed she would not be able to control her impulses in many settings not just at home with her parents. In April's case she is not being unruly when with other family members or at school. The assumption, then, by many, is that her home environment is a negative one.

Yet, in April's case she may have an internal dysfunction rather than experiencing a negative home environment. She may, for example, have an internal dysfunction that is triggered only by close relationships. As her parents are the ones providing the closest of

relationships it would make sense that the internal dysfunction is being triggered only in the home environment. There are many mental and physical disorders that are only triggered at certain times. For example, hayfever may cause a runny nose, and itchy and watery eyes. These symptoms may be seen all year round when someone is inside and outside. Yet, for some, the symptoms are only seen during warm and humid seasons, and when outside. As another example, consider a depressive disorder. The symptoms may include low mood, fatigue and a reduced appetite. In some, these symptoms may be seen all year round. However, others may have seasonal affective disorder, which is triggered and seen in only certain seasons. In these examples, it does not follow that the symptoms have to be seen across multiple settings to be viewed as an internal dysfunction.

April may be experiencing a negative environment, such as hostile parenting, *and* have an internal dysfunction, whatever an internal dysfunction may be. The DSM-5 (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*') says, "children with oppositional defiant disorder may have experienced a history of hostile parenting, and it is often difficult to determine if the child's behavior caused the parents to act in a more hostile manner toward the child, if the parents' hostility led to the child's problematic behavior, or if there was some combination of both". The DSM-5 is not considering here whether someone has an internal dysfunction, but their point has relevance. Hence, it is not always possible to say that those living in a negative environment, such as experiencing hostile parenting, do not have an internal dysfunction as well.

All the points in this section show that saying someone has an internal dysfunction does not determine who should be offered interventions from a specialist, secondary mental health service. Firstly, it is not always possible in practice to say when unruly behaviour is an internal dysfunction, whatever an internal dysfunction may be, due to a strong interlink with

the environment. Secondly, if it were always possible to determine when unruly behaviour is an internal dysfunction, then having an internal dysfunction would not always mean that an intervention from a specialist, secondary mental health service is needed. A child or youth may need an intervention that is directed at the situation. The reason why an intervention directed at the situation may be needed is that the environment, such as poverty, is contributing to the cause of the internal dysfunction or the internal dysfunction has caused a negative environment, such as hostile parenting. Hence, the best course of intervention is to offer whatever is clinically judged to be of help. This may involve an intervention from a specialist, secondary mental health service, an intervention that is directed at the situation, or both.[87]

There are a further two points about the internal dysfunction view that I will make separately to the example of the study and the composite case. Firstly, even if it were always possible to determine when unruly behaviour is an internal dysfunction, having an internal dysfunction would not always warrant an intervention from a specialist, secondary mental health service or an intervention that is directed at the situation. A child or youth may need no intervention. For instance, imagine a youth who has an internal dysfunction in empathy. They are unmoved when a peer is upset or on hearing stories of individuals suffering around the world. However, this lack of ability to be empathic allows them to be more analytical in their thinking. The youth is able to achieve their academic goals with their analytical thinking

[87] When discussing ODD the DSM-5 (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*') says that "In the event that the child may be living in particularly poor conditions where neglect or mistreatment may occur (e.g., in the institutional settings), clinical attention to reducing the contribution of the environment may be helpful".

ability. They are not able to form close relationships due to their inability to be empathic. The youth is argumentative and disruptive with anyone who tries to form a close relationship with them; yet, this causes no concern for the youth. I would not want to say that this youth requires an intervention.

Secondly, a child or youth may need an intervention and not have an internal dysfunction, whatever an internal dysfunction may be. For example, imagine a youth who has no internal dysfunction in impulse control. However, her level of impulsivity causes her distress. She wishes that she was daring and took more risks to pursue her goals, rather than always considering the consequences. She feels like her life has no excitement because her peers have great stories to tell about their adventurous and dramatic lives. The youth is calm and has a measured approach to making decisions. She is able to resist impulsive thoughts and behaviours. Yet, this causes concern for the youth. I would want to say that this youth does require an intervention.

These two additional points show that saying someone has an internal dysfunction does not determine whether an intervention is required. Further information is needed to understand the experience of the individual and the problem. That further information helps judge what, if any, intervention is warranted and whether the individual should be offered interventions from a specialist, secondary mental health service. I say more about understanding the experience of the individual and the problem in chapter six (pp. 157-160).

Before I present the "scientistic definition" and the "social constructionist definition", I will pause to borrow the work from the philosopher Quill Rebecca Kukla (writing as Rebecca Kukla 2014).

Definitions of disorder

Despite the amount of work theorists have done towards creating a single definition of disorder the task has not been achieved. There are many definitions of disorder in the literature that cover the physical and mental domain. For example, some definitions say that disorders are natural dysfunctions; however, there is wide debate over what natural function and dysfunction are (see for example Griffiths and Mathewson 2018). There is also the view that a disorder is a natural dysfunction that is disvalued (Powell and Scarffe 2019). Another definition is that a disorder is a presentation that "is a bad thing to have, . . . such that we consider the afflicted person to have been unlucky, and . . . can potentially be medically treated" (Cooper 2002, 271).[88] There are more definitions. The literature covering the different definitions, problematic cases and limitations of the definitions is vast.

However, having different projects is likely to mean that we require different definitions of disorder. As Kukla (2014, 515) says, and I agree, there is no reason to expect to find a single definition of disorder. Kukla (2014, 515-516) points out that if someone is embarking on a "scientific project" then their definition may come from the perspective of the natural sciences; yet, for those interested in social justice a notion of disorder "may be less central". Hence, depending on the aim of the project different definitions will appeal.

I will use two definitions of disorder to show that having a mental disorder is not sufficient for warranting interventions from a specialist, secondary mental health service. The first definition is the "scientistic definition" and the second is the "social constructionist definition".[89] The "scientistic definition" is interested in what the natural sciences tell us

[88] Rachel Cooper (2020, 152) has recently said that she once thought a necessary condition for a disorder was being harmful for the individual, but she now thinks this is questionable.

[89] I am borrowing Kukla's (2014) terms from their work on definitions of health. The explanations of the terms are my interpretation influenced by Kukla (2014).

about the nature of disorder. This definition is significant because it is widely discussed in the literature. The "social constructionist definition" identifies disorders according to what is condoned by society at the time. This is an interesting definition because it considers social attitudes and political motivations. I make no claims about whether I agree with these definitions, and the definitions were not intended to answer my question: who should be offered interventions from a specialist, secondary mental health service?

The "scientistic definition"

A prominent scientistic definition of disorder is presented by the philosopher Christopher Boorse. The philosopher Rachel Cooper clearly summaries Boorse's theory of health and disorder. She says:

> Boorse holds that we can think of the human organism as being made up of various subsystems (which include solid organs, such as kidneys, and also diffuse systems such as the nervous system). Each subsystem has a normal function, which is whatever it normally does in comparable organisms that contributes to survival and reproduction (Cooper 2013, 488).

According to Boorse's (1977, 555 and 562) theory, health is "the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency". He defines disorder as "a type of internal state which impairs health, i.e. reduces one or more functional abilities below typical efficiency" (Boorse 1977, 555). To summarise, typical (statistical) normal functioning would equate to health and a disorder is below typical (statistical) normal functioning. To put it another way, disorders are natural statistical dysfunctions.

"Natural" [90]

Before I continue, it is worth pausing to say how I am using the term "natural". I am using the term "natural" to apply to both the mental and physiological. On mental functioning Boorse (1976, 64) says:

> it is easy to draw some of the outlines of human mental functioning.
> Perceptual processing, intelligence, and memory clearly serve to provide information about the world that can guide effective action. Drives serve to motivate it. Anxiety and pain function as signals of danger, language as a device for cultural co-operation and cognitive enrichment, and so on. If these and other mental processes play standard functional roles throughout the species, we seem to have everything requisite for the possibility of mental health.

Hence, I am using "natural" to cover the range of the mental and physiological, so the term "scientistic" is not limited to the physiological sciences.

Does meeting the scientistic definition of disorder determine who should be offered interventions from a specialist, secondary mental health service?

In their work Kukla does not ask my question: who should be offered interventions from a specialist, secondary mental health service? Yet, they do point out that saying that something is a scientistic defined disorder "does not imply that it ought to be treated, that it is bad to have it, or anything of the sort" (Kukla 2014, 517). The goal of the scientistic definition is to give a "scientifically sound definition" (Kukla 2014, 517). Boorse's

[90] I have drawn upon personal correspondence with the philosopher Tim Thornton to write this section, June 2020.

definition, then, does not determine who should be offered interventions from a specialist, secondary mental health service. The typical (statistical) below-normal functioning of a part or process does not equate to having a negative impact on one's life that requires intervention. To illustrate this, consider the case of NSSH in youth.

Non-suicidal self-harm[91]

In chapter two I argued that NSSH in youth is never a mental disorder in its own right. However, for my claim, I will assume that someone has been able to determine what part or process causes NSSH, and then found the natural function of this part or process. She has then discovered that this part or process is functioning in a typical (statistically) below-normal way in youth who engage in NSSH. Hence, according to the scientistic definition, NSSH in youth is a disorder.

Yet not every youth who engages in NSSH requires an intervention to stop the harming behaviour. For example, consider the composite case of Alison presented in chapter one. In chapter one (pp. 32-36), I asked you to consider Alison being brought in to see you, as a clinician, by her parents. I presented Alison's case in different ways to show how to use the four-question-analysis to make a clinical judgment about whether Alison is engaged in NSSH. As I will present her case in this chapter, she is clearly engaged in NSSH.[92]

[91] In parts of this section I use my public opinion piece titled '*Accepting self-harm*' (Ahir-Knight 2019).

[92] In chapter six (pp. 158-160) I say more about Alison's case and point out that, although she does not require an intervention that targets the NSSH, she does require an intervention for other reasons.

Alison is a 14-year-old female. She has been cutting her arms most days for roughly six months. She cuts herself with a blade from a pencil sharpener. Alison carries a purse with her that contains the blade, antiseptic wipes and plasters. She cuts herself privately in the toilets at school or in the bathroom at home. She finds relief in seeing the blood when she cuts and harming herself makes things feel real. After she has cut herself she takes time cleaning and dressing the cut. This helps her feel like she can make things better. Alison has no intent to kill herself. To conceal what she is doing she wears long-sleeved tops and she stopped going swimming at school. Her parents discovered what she was doing when Alison's mother became suspicious of the amount of time she was spending in the bathroom and walked in on her.

Before seeking help from a clinician Alison's parents searched the Internet for resources and found strategies to target NSSH. They attempted to encourage Alison to replace the non-suicidal self-harming behaviour with something that causes less or no physical injury.[93] For example, replacement behaviours include flicking her skin with a rubber band, holding an ice cube against her skin and drawing red lines on her skin. In the clinical literature and in practice these are sometimes referred to as "substitution methods" (for example, Dickens and Hosie 2018, 529). "Substitution methods" involve one behaviour being substituted for another behaviour.

An interesting question is whether some substitution methods are still forms of NSSH. For example, Wadman and colleagues (2019, 6 12-14) conducted a study that said some young people reported flicking rubber bands as a form of NSSH. To illustrate how a substitution method meets the definition of NSSH I am using, consider flickering a rubber

[93] The strategy of replacing the harming behaviour is a common strategy offered by self-help resources and by clinicians (Wadman et al. 2019, 2).

band against the skin. This behaviour may cause damage to the body tissue in the form of scratches. The flicking of the rubber band is done deliberately by the person without suicidal intent. This, then, meets the definition of NSSH that I am using in this dissertation. I will put this question aside and say that substitution methods are interventions that set out to stop the *original* harming behaviour.

In Alison's case the strategy of using substitution methods does not stop her from cutting herself. She reported that she uses NSSH as a coping strategy, which she finds effective. When Alison was asked about the use of substitution methods, she said that she does not find this strategy helpful. Alison is not alone in finding substitution methods unhelpful. Further empirical research is needed to determine the effectiveness of substitution methods, but a small research study has shown that most young people do not find substitution methods helpful (Wadman et al. 2019).

Alison is coping with events that would be expected during this stage of her life. For instance, she is coping with academic pressures and difficulties in peer and romantic relationships. If Alison were struggling with pressures due to an unjust society, such as poverty, bullying and discrimination, then there would be reasons to tackle those situations. However, for Alison, this is not the case.

Alison recognises there are negative consequences of her engaging in NSSH. For her the negative consequences are gaining a few scars, no longer going swimming and wearing long sleeves in the warmer weather. Yet, Alison finds the benefits of NSSH outweigh the costs to her. Alison may have a part or process that is functioning in a typical (statistically) below-normal way, so that she engages in NSSH, but that does not affect her life in any way that is of importance to her. The question, then, is, what benefit is there in intervening with Alison to stop the harming behaviour?

One response may be that an intervention is required because Alison is causing herself physical harm. However, during this stage of life, many youth experiment with different coping approaches because they are developing an array of different skills. Youth are learning ways to cope and manage distressing emotions and thoughts. This means that youth, perhaps, habitually resort to using ways to cope that may be destructive. Hence, the intervention is not to target stopping the behaviour. Instead, the intervention to use is what are referred to in the clinical literature and in practice as "harm reduction methods" (for example, Dickens and Hosie 2018, 529).[94] "Harm reduction methods" aim to reduce the physical injury caused by the non-suicidal self-harming behaviour. For example, someone engaged in NSSH by means of cutting may be taught how to clean their cuts and have access to clean instruments to cut themselves with to avoid infections. Alison is already using a clean blade and treating her cuts, so she is already reducing the harm of physical injury.

Some may say there is another reason to intervene with Alison to stop the harming behaviour. The reason to target the NSSH is that Alison's NSSH may influence others to harm themselves. This is sometimes referred to as "NSSH contagion" in the clinical literature and in practice (see, for example, Hasking et al. 2016, 654-656). The researchers Walsh and Rosen (1985 cited in Hasking et al. 2016, 654) have defined the contagion of NSSH in two ways: (1) when two or more people within the same group engage in NSSH within 24 hours, and (2) when there are statistically significant clusters of NSSH within a group. Further

[94] These methods are also interchangeably referred to as "harm minimisation methods". I have chosen to use "reduction" rather than "minimisation" as often the method is to reduce rather than minimise the physical injury. A clear definition of the terms is lacking, so this would be an interesting piece for further research. I understand the bioethicist Angus Dawson has started some work on the terms, which are used for other phenomena as well as NSSH.

research is needed into NSSH contagion; however, it is currently thought that showing recent NSSH wounds and discussing details of NSSH, such as the methods used, may trigger NSSH in others (Hasking et al. 2016).

In Alison's case there is a low likelihood of contagion. She is concealing her NSSH by cutting herself in private, covering the areas on her body where she causes harm and avoiding activities, such as swimming, where she would reveal her cuts. She does not discuss the details of her NSSH with her peers. Alison does this to conceal her NSSH. She feels the need to conceal her harming behaviour due to feeling guilt and shame. She feels guilt and shame due to how others view NSSH. She wants to conceal her NSSH because she thinks others will try to make her stop. Her parents have come to understand her behaviour, so she no longer feels the need to conceal the NSSH from them. This allows her to wear short-sleeved tops at home. Yet, due to the societal view of NSSH, she is not able to wear long-sleeved tops or go swimming. However, even if the societal view was to change there is still a question here of the impact NSSH may have on others.

Now suppose that Alison is engaging in NSSH in the classroom in front of others and exposing the cuts on her arms for others to see. In this case there may be a need for an intervention to stop the harming behaviour. In the first instance Alison would be encouraged to engage in NSSH privately and keep her arms covered; however, if she does not comply then an intervention would be offered to stop her engaging in NSSH. This is because of the impact on others.[95]

[95] Saying that it is acceptable for Alison to engage in NSSH is different from saying NSSH should be encouraged. If there is an NSSH contagion then allowing the public display of

There are different ways that engaging in NSSH in front of others and widely exposing cuts may impact others. There is the potential for the contagion effect of NSSH. Furthermore, cutting oneself in front of others, exposing cuts and discussing the details of one's NSSH is distressing for others whether it encourages NSSH in others or not. Additionally, when Alison engages in NSSH in her classroom this takes away the teacher's attention from teaching. This is because the teacher has to deal with the harming incident. Hence, Alison's relationship with others and the welfare of others should be considered when determining whether to intervene.[96]

NSSH in youth, then, sometimes does and sometimes does not warrant an intervention. It is not the case that all those who have a part or process that is functioning in a typical (statistically) below-normal way always warrant an intervention. Hence, the scientistic definition of disorder does not determine who should be offered interventions from a specialist, secondary mental health service.

I now present the "social constructionist definition".

The "social constructionist definition"

NSSH and cuts, and discussing the details of one's NSSH may be viewed as encouraging the behaviour.

[96] In chapter six (pp. 165-166), I discuss, with the case of unruly behaviour, how having no desire to stop a behaviour is not always in one's best interest and I pose the question of whether interventions should be offered when they will advance social welfare rather than the welfare of the service user.

In their work on health and disorder, Kukla discusses another definition. They refer to this second definition as "a social constructionist approach" (Kukla 2014, 517-519). Kukla (2014, 517) says:

> This approach begins from the recognition that health and disease are phenomena that are embedded in social practices and fraught with social meanings. Diseases do not merely physically impair us or make us uncomfortable; they co-travel with a variety of social possibilities, barriers, and connotations, which shift and reconfigure over time. Health is not a socially neutral state; it varies demographically and takes on meanings that are shaped by class, race, and other social markers. Clusters of symptoms may start out having no unified medical meaning, and become 'medicalized' over time.

They go on to say that in an "extreme form" a social constructionist definition may say "*A condition or state counts as a disease if and only if it is medicalized, where medicalization is a social and institutional process, and health is the absence of disease*" (Kukla 2014, 517). This means that something is a disorder when it is recognised to be one, by those who have the authority to say so, such as health institutions.

Kukla (2014, 518) gives examples of how disorders will change over time under the social constructionist theory. They use the examples of homosexuality and drapetomania (slaves wanting to escape) to say that medicalisation is "driven in part by political and cultural forces" (Kukla 2014, 518). They point out that drapetomania was no longer considered a disorder when society moved to see slavery as objectionable. Furthermore, they note that homosexuality was demedicalised at the same time as the movement for sexual civil rights.

Does meeting the social constructionist definition of disorder determine who should be offered interventions from a specialist, secondary mental health service?

Meeting the social constructionist definition of disorder does not determine who should be offered interventions from a specialist, secondary mental health service. This is because those with the authority to say something is a disorder, such as health institutions, have the power to medicalise for unjust reasons and be influenced by social attitudes. To illustrate this, consider the case of unruly behaviour in children and youth.

Unruly behaviour

To illustrate medicalisation for unjust reasons, consider the case of Annie, whom I presented earlier in this chapter to illustrate meeting diagnostic criteria and not warranting an intervention from a specialist, secondary mental health service. Annie lives in a society where females over the age of 14 years old are not legally allowed to continue gaining an education; instead, the societal norm is to gain employment. Her unruliness is about those unjust norms. Her behaviour does not warrant an intervention that targets stopping the unruly behaviour because she is trying to gain an education. I suspect that many would agree gaining an education is good for one's welfare. Instead, an intervention is needed to target the unjust society she lives in.

However, someone may have the view that females should not be able to gain an education so use her unruliness to say she has a mental disorder. As Kukla (2014, 518) says:

> if what counts as health or as disease is subject to the vagaries and contingencies of social history and attitudes, and is not directly constrained by discoverable natural facts, then it is hard to see how these notions could serve as stable grounds for normative claims about rights, just social arrangements, and so forth.

Annie's behaviour may, then, be medicalised as a disorder that requires intervention because it suits the unjust society she lives in.

To illustrate medicalisation that is influenced by social attitudes here is the composite case of Jane again from earlier in this chapter, who illustrated meeting the diagnostic criteria for both ODD and conduct disorder. In the earlier case, Jane is a 14-year-old female. Now consider Jane's case but imagine the young person is a 14-year-old male called James. There is a societal view that males are more likely to be perpetrators of violence. The influence of this view may mean that James's behaviour will not be medicalised but, instead, viewed as usual male behaviour. Yet, for Jane her behaviour may be medicalised because as a female she is not socially considered to be violent. This means that on the social constructionist view, then, James may not have a disorder while Jane does.

However, whether Jane or James is categorised as having a mental disorder should not determine whether an intervention is warranted. Instead, of determining what is considered disordered by social attitudes, what is of importance is the impact the behaviour has on one's welfare.[97] As I pointed out earlier in this chapter (pp. 119-120), when discussing oppositional defiant disorder and conduct disorder, research shows that there are many negative outcomes to unruly behaviour. Negative outcomes include a risk of problems with relationships. Also, there is an increased risk of developing mental disorders, such as depression and anxiety, and (when adults) a personality disorder. Other negative outcomes include criminal activity, involvement with gangs, being homeless, a low education standard, suicide, physical health

[97] It is interesting to note that the DSM-5 says a diagnosis of oppositional defiant disorder and conduct disorder should be considered relative to what is normative for age, gender and culture (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*').

problems, such as cardiovascular difficulties, and early mortality. In Jane and James' cases, their welfare, now and in the future, will be negatively impacted if an effective intervention that targets the unruly behaviour is not offered.

Meeting the social constructionist definition of disorder, then, does not determine who should be offered interventions from a specialist, secondary mental health service.

Conclusion

To conclude, firstly, I showed that someone who is judged to have a mental disorder by virtue of meeting diagnostic criteria does not always warrant an intervention from a specialist, secondary mental health service. Secondly, I said that saying someone has a mental disorder because they have an internal dysfunction does not determine who should be offered interventions from a specialist, secondary mental health service. In this case further information is needed to understand the experience of the individual and the problem to help judge what, if any, intervention is warranted. Lastly, I suggested that it is not the case that those who meet the scientistic or social constructionist definition of disorder should always warrant an intervention from a specialist, secondary mental health service. In other words, I have shown that on *any* plausible theory or definition of disorder, it is not the case that all those with mental disorders should always be offered interventions from a specialist, secondary mental health service. In this chapter, then, I have claimed that having a mental

disorder is not sufficient for warranting interventions from these services. Elsewhere, in this dissertation, I have shown that having a mental disorder is not necessary either.[98]

[98] See chapter four (pp. 109-110) where I sum up where I have shown in this dissertation that having a mental disorder is not necessary for warranting an intervention from a specialist, secondary mental health service.

Chapter six: rethinking mental disorder and intervention

In this chapter, I offer some insights about mental disorder, based on my work from the previous chapters. Firstly, I say that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are not mental disorders. Next, I say that managing life in the best way one can with the abilities available at a particular stage of life is not disordered. Lastly, I say that whether one has a mental disorder should not determine whether one is offered interventions from specialist, secondary mental health services.

Then I ask the question: what are the necessary conditions for offering interventions from a specialist, secondary mental health service? I say that, rather than depending on whether a person has a mental disorder, interventions from these services should be offered only when they will advance the welfare of the service user. I then explain why I apply my insights to mental disorders and not physical disorders. I end by discussing an overarching theme of this dissertation, which is that we can make significant progress on philosophical questions about mental disorder and intervention without committing to a particular definition or theory of mental disorder.

I start with my claim that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are not mental disorders.

Passing phases and producing goods

Imagine a friend finds me, a grown woman, on a sofa in an odd position. I am sitting, so my head is where you would ordinarily find my feet and my feet are where you would ordinarily find my head. My view of the room is upside down and I am staring out the window. When my friend, Andrea, asks what I am doing, I respond by whispering to her to be quiet. She often finds me hanging upside down on the sofa staring out the window.

Sometimes she sees me outside hanging upside down off tree branches. There have been times I have climbed to the top of trees and tried to reach even higher. I badly sprained my wrist once having fallen from a tree.

Andrea is worried about my odd behaviour, so she asks once again what I am doing. This time, as I am hanging upside down on the sofa, I tell her. I explain that there is another world in the sky hiding behind the clouds. There are brightly coloured talking teddy bears in this world who are hiding from the fire-breathing dragons who circle the sky. I say if she is quiet and looks at the sky upside down, she may see the foot of a teddy bear hanging off a cloud. She may even see the wing of a dragon between the clouds as it hunts for the teddy bears. I then excitedly point to the sky and ask her, "Did you see it?!"

My friend is now very worried. She does not have any clinical training, but she questions my mental state. She is not worried that I am experiencing visual hallucinations. She believes me when I say I am playing. She is worried about the type and intensity of the play I am engaged in, so she seeks advice from a mental health service.

This hypothetical situation is based on a true story. In the accurate version, I was a child, not a grown woman. Andrea (a pseudonym) was also a child.

In my accurate childhood story the type and intensity of the play did not raise concerns about my mental state. Andrea did keep asking me what I was doing. I eventually told her about the other world behind the clouds. She never questioned my mental state. When I asked her if she saw the teddy bear's foot hanging off the cloud she excitedly jumped up and down saying she saw the foot too. Some adults in our life knew about the other world behind the clouds and expressed no concerns. The adults also knew about our imaginary tea parties, protecting ourselves from the flame-throwing robots and climbing Everest before breakfast. The adults never expressed any concerns about our mental states because, as we

were children, we were viewed as being engaged in the characteristic child behaviour of imaginative play.

Imaginative play is important in childhood because it may help with development. Most, if not all, will agree that different types of play may help children to develop, and the field of developmental psychology has many theories about this (see Hayes 2000, 655-664 for a summary). Through play, children may learn to understand the world and gain control of their environment (Hayes 2000, 655-664). Specifically, imaginative play may help children with their reasoning, early language, narrative and emotional regulation development (Lillard et al. 2013, 11, 17-21 and 23-25).

It is also suggested that imaginative play is important for the development of mature agency. As the philosopher Tamar Schapiro (1999, 732) suggests, play is a form of work for children who need to "become themselves". Schapiro (1999, 732- 733) states "play" and not "imaginative play", however, what she discusses strongly advocates the need for imagination in play. She says:

> By engaging in play, children more or less deliberately "try on" selves to be and worlds to be in. This is because the only way a child can "have" a self is trying one on. It is only by adopting one or another persona that children are able to act the part of full agents, to feel what it must be like to speak in their own voices and to inhabit their own worlds (Schapiro 1999, 732).

According to Schapiro, then, it is specifically *imaginative* play that serves an important function in the development of mature agency.

Imaginative play is important during this stage of life too. The philosopher Colin Macleod (2015, 59) suggests that imagination is "amongst the goods that can be a source of intrinsic value in the lives of children". Macleod (2015, 60) says that a child's life is

"enriched" by being imaginative. He points out that when a child grows up too quickly, by for example having demands placed on them, there is a significant loss due to their shortened childhood (Macleod 2015, 53-54 and 60-62).

To illustrate what Macleod says, I offer the example of a child having to care for a very ill parent.[99] The child may develop responsibility and empathy, which may be considered valuable; however, she will experience the loss of childhood goods, such as having limited responsibility, innocence and imaginative play. When she is faced with the harsh realities of caring for a loved one she will not be left with space for a life filled with a world behind the clouds, imaginary tea parties, flame-throwing robots and climbing Everest before breakfast. She might grow up too quickly and lose out on her childhood.

Adults may engage in imaginative play as well. For example, adults may re-enact battles and pretend they live in medieval times. However, adults do not engage in the intensity of imaginative play that children engage in. An adult's day is not spent consumed with imaginary friends and make-believe worlds. If an adult acted in this way it would be odd and there would be concerns about their mental state. An all-consuming kind of imaginative play, then, is unique to childhood. It passes, rather than continuing into adulthood.

The example of the make-believe world of talking teddy bears and fire-breathing dragons is an illustration, then, of how there are behaviours and thoughts characteristic in children but abnormal in adults. This is because all-consuming imaginative play is part of a passing phase and produces goods of childhood. I am not suggesting that it is necessary for

[99] Macleod (2015, 58) says that "Children who 'grow up quick' are often children who are expected at a young age to assume significant responsibilities for managing their own welfare and the welfare of others".

every child to engage in these behaviours to have a good human life; however, there are reasons to think that engaging in these behaviours is good for some people during childhood.

Hence, it would be odd to consider a child engaged in all-consuming imaginative play as having a mental disorder. This is because it is odd to say that behaviours that usually pass after a while and produce goods for that time in life are mental disorders.

In chapter two, I claimed that non-suicidal self-harm (hereafter referred to as "NSSH") in youth is never a mental disorder in its own right. I said, instead, that NSSH in youth is a characteristic youth behaviour. "Characteristic youth behaviours" are behaviours that present temporarily, as part of a passing phase, and produce goods of adolescence.

Characteristic youth behaviours are instrumentally valuable because they help with development. These "characteristic youth behaviours" include behaviours that may commonly be considered, perhaps, risky, harmful, destructive, irrational and reckless. For instance, youth may dive from high bridges into rivers, do skateboarding tricks without any protective clothing, go travelling to remote areas alone, or risk arrest and even their lives by organising activist movements. Children and adults engage in characteristic youth behaviours too; yet, it is not characteristic for a child or adult to engage in many of these types of behaviours and at an extreme level as youth do. "Characteristic youth behaviours" are behaviours that present temporarily as part of a passing phase in one's life. It is odd to say that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are mental disorders.

Similarly, it is odd to say that forms of unruly behaviour that are usually part of a passing phase and produce goods appropriate to that phase of life are mental disorders. In chapter four I said that some forms of unruly behaviour are instrumentally valuable, produce goods and are useful for development. I also said that, in some cases, it may advance an

individual's welfare to encourage a disposition to display unruly behaviour. It is odd to say that these forms of unruly behaviour are mental disorders as well.

Next, I discuss my suggestion that managing life in the best way one can with the abilities available at a particular stage in life is not disordered.

Managing life as best one can

During childhood and adolescence many will experiment with different coping approaches.

Children and youth need to explore different approaches as part of their development of new skills. To illustrate this, consider a child who is upset because their playmate has a toy she wants to play with. First, she copes with this situation by hitting her playmate in an attempt to obtain the toy. She tries this approach at a few playdates before she learns to try something different. She trials numerous strategies, often testing a strategy many times. She experiments by grabbing the toy, offering her playmate something else to play with, crying, distracting herself, and playing together with her playmate. Some strategies are more effective than others for obtaining the toy she wants, easing her suffering or both. However, all the strategies help her develop skills. For example, when she grabs the toy from her playmate in an unruly way this makes her parent angry and her playmate cry. She also does not get to play with the toy as it is swiftly returned by her parent to her playmate. This helps her to learn that her actions affect others and that her actions may make others angry or upset. Furthermore, seeing her playmate crying upsets her, so this helps develop her ability to relate and empathise with others. By trying to grab the toy many times she is exposed to the repetitive learning of important skills. Hence, she needs to experiment with different approaches many times as part of her development.

Furthermore, a child or youth may experiment with different approaches because they have not developed an array of different skills. For this reason, I suggest that there are different expectations for children and youth compared to adults. For example, there is less of an expectation that a child or youth has developed the skill to cope with overwhelming feelings. That is why a wailing child who is disruptive by refusing to put on their pyjamas even though they are tired is tolerated, but an adult acting in the same way would be odd. Also, this is why the heartbreak of a young person who was dating someone for a week is tolerated, but if an adult acted in the same way it would be odd. The wailing child and the heartbroken youth do not have the same skills an adult has to cope with the emotions these situations raise, and they need to experiment with different approaches as part of their development.

Additionally, coping in what may appear a destructive, abnormal and irrational way may be more tolerable because childhood and adolescence is a period of rapid change. This means that thoughts and behaviours that a child or youth engage in are more likely to change, compared to those of adults.

To illustrate how childhood and adolescence are periods of rapid change, consider the development of a child's behaviours and thoughts as she grows. At the age of 3 to 4 months, she reacts positively to things and people familiar to her. At 18 months, she becomes very bossy and wants to have everything she likes. The reason is that she thinks everything she likes is an extension of herself so belongs to her. Between 2 and 3 years old everything will lead to an unruly tantrum and she will often use the word, "no!" She will also move from wanting to be independent, so doing things for herself, to wanting to be dependent and cared for by others. For example, she will demand that she puts her clothes on herself and then quickly change her mind and request that her parent help her. When she is 4 years old, she develops a fear of the dark and her parents leaving, which passes when she gets slightly older.

At 5 years old, she has learned that discussing and showing your genitals is not acceptable, so to gain a reaction, she tries to shock others by shouting out words for genitals or lifting her skirt. When she is 7 years old, she becomes very affected by life. She used to not worry, but now she is excessively worried, and all aspects of her life are an enormous problem. At 9 years old, her friends become more important to her and she will prioritise them over her family. She wants to spend more time with her friends. When she is 10 years old, she becomes very literal about everything, so she expects others to do exactly what they say. To make sure people do exactly what they say, she makes others make promises, which are not to be broken.

When she develops further as a youth there are many more changes. For example, during adolescence friendships and romantic relationships are much more stressful. Youth will try to assert their independence more, and they will experiment with their image and identity. They will also engage in characteristic youth behaviours. In comparison, adults do change but there is not the same level of rapid change. Hence, a child or youth coping in a destructive, abnormal and irrational way may be more tolerable because there is an expectation their behaviours will rapidly change.

As I pointed out in chapter two (pp. 48-49), youth often use NSSH to try to cope with external problems and understandable yet distressing emotions and thoughts. An adult engaging in NSSH to cope would be less tolerated. There is an expectation that an adult would have developed other ways to cope with intense emotions or not be experiencing emotions so intensely. Yet, youth using NSSH is tolerable because they often have many things to manage without an adult range of coping strategies. Likewise, a child or youth who is displaying unruly behaviour to cope with external problems and overwhelming emotions and thoughts is tolerable because they are yet to develop the range of adult abilities. It is odd

to say that someone has a mental disorder for trying to manage life in the best way they can with the abilities available to them at their stage of life.

I now turn to my last observation about mental disorder.

Having a mental disorder should not determine whether one is offered interventions from specialist, secondary mental health services

In this dissertation, I argue that having a mental disorder is neither necessary nor sufficient for warranting interventions from specialist, secondary mental health services. Rejecting the assumption that "those with mental disorders" should be offered interventions from a specialist, secondary mental health service may appear revolutionary. However, the philosophers Rebecca Roache and Julian Savulescu (2018) point out that in other areas of medicine, clinicians are not focused on offering interventions to treat disorders. Roache and Savulescu (2018, 248) are discussing a "disease-focused conception of medicine" when they say:

> in fact much of medicine operates without this conception. For example, the field of obstetrics is not characterized with reference to disease. Much of optometry is concerned with correcting problems that are characterized in terms of their negative effect on patient's lives rather than with identifying and treating diseases.

Hence, saying that having a mental disorder is neither necessary nor sufficient for warranting interventions from specialist, secondary mental health services should not appear a revolutionary claim.

If we keep the assumption, that "those with mental disorders" should be offered interventions from a specialist, secondary mental health service, this continues to give

substantial power to a mental disorder diagnosis: that a mental disorder diagnosis is needed in order to say someone is worthy of an intervention.

Furthermore, as I pointed out in chapter two (pp. 66-67), one view is that a mental disorder diagnosis is needed to aid the legitimisation of human suffering, and to encourage others to show compassion to those who are struggling. Yet, mental suffering is an expected response for many reasons not only due to having a mental disorder, whatever one may view a disorder to be. Mental suffering deserves compassion and to be alleviated by those who have the ability to help.

To illustrate this, consider the example of suffering from a depressed mood. Imagine someone is struggling to get out of bed in the morning and to find joy in their interactions with their loved ones. The person is pained by thoughts about a bleak future and their unworthiness. In this case what is of importance when determining whether we should intervene to attempt to alleviate their suffering? I say that one thing of importance is attempting to gain an understanding of the experience of the individual. The reason gaining an understanding of the experience is of importance is that it can help determine what intervention may be most helpful. For example, someone experiencing a depressed mood due to bereavement may find an intervention that involves talking about their loss most helpful. Someone who is experiencing a depressed mood due to being bullied may require an intervention that tackles the bullying. Plus, someone who is experiencing a depressed mood, perhaps, due to some inflammation or chemical imbalance in their brain may benefit from pharmacological intervention. All these people deserve an intervention. Their suffering is legitimate. Plus, their struggles should motivate compassion from others. Whether their depressed mood is a disorder should not determine whether they access interventions from a specialist, secondary mental health service if needed.

When determining what intervention to offer, understanding the experience of the individual and the problem is important. “Clinical formulations” are used by clinicians to understand and clarify what may be contributing to the suffering or problems.

Clinical formulations

The skill of case formulation is commonly taught to clinicians, and many clinicians routinely use clinical formulations in their practice (Sturmey 2009, xxi). “Clinical formulations” allow clinicians to hypothesise about the behaviour, problem, symptom or disorder more broadly. (“Clinical formulations” are not classification frameworks, such as the ICD-11 and DSM-5 and “clinical formulations” are not used to diagnose a disorder.) A common formulation approach (Weerasekera 1996) considers the problem and what makes someone vulnerable in the first place, for example, the way they were born, the things that have happened to them and, perhaps, having a mental disorder.[100] Additionally, the approach asks why the problem has happened now and what keeps the problem going. Furthermore, formulations look at what stops the problem from getting worse, such as their individual and environmental strengths. “Clinical formulations” help clinicians determine the best type of intervention to offer to the service user, and if the clinician explains the formulation to them and their family, this provides an understanding of the problem. [101]

[100] I say “perhaps” having a mental disorder for two reasons. Firstly, I want to avoid the assumption that having a mental disorder always contributes to the presenting problem. Secondly, I use perhaps because the clinical formulation developed may be about the mental disorder.

[101] Clinicians use different theoretical approaches to clinical formulations (for comprehensive examples see Sturmey 2009). The content of the clinical formulations for the same person

To illustrate a clinical formulation here is Alison's formulation. Alison is the composite case I presented in chapters one and five who is engaged in NSSH. Alison lives with her mother, father and two older siblings. She describes a happy upbringing, but she also reports concern and distress because she does not feel like she fits into her family. She states that this is because her two older siblings were born closer together and so have more in common. Her mother, who was her main caregiver when Alison was younger, reports that there were no problems during infancy, and there were no complications with the pregnancy and birth. Her father reports that Alison started developing high expectations of herself when she was eight.[102] He recalls once she cried and cried just because she did not get picked for the lead in a school play. Her teacher has no problems with Alison and describes her as a star student. He elaborates, saying she never gets into trouble, has friends and her schoolwork is of a high standard. She also takes part in extra curriculum activities outside of school, such as music and athletics.

When Alison is asked why she started self-harming she states that she accidentally nicked herself with a knife one day. Nicking herself with the knife took away (what she refers to as) the bad feelings about herself. When the bad feelings returned she tried pinching herself, but it did not have the same effect. It was seeing the blood that made her feel better.

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may, then, be different depending on the approach the clinician has used. Sometimes there may be modest differences in the formulation for the same person, but sometimes there are vast differences that result in the person being offered different interventions (to illustrate the vast differences see Sturmey 2009, part vi).

[102] A clinician would explore the development of her high expectations. Some of the questions the clinician would ponder is why at this age, who else in Alison's life has high expectations, and does her place in society, such as her gender and class, influence her expectations?

This then progressed to cutting herself. The reason why she continues is that she has found a method that helps her deal with her bad feelings. When asked further about the bad feelings she states that she thinks badly of herself due to not getting the school results she wants, and when she has difficulties with her friends and a boy she has a crush on.

To summarise, it appears that Alison had an uneventful period during her early years. On the one hand this means she had no events that would have interrupted her development. However, this also means she has not been exposed to experiences where she has needed to manage negative events.[103] She also does not have a strong sense of belonging with her family, and she has developed high expectations of herself. These are all factors that may make Alison vulnerable in the first place to engage in NSSH. NSSH has occurred now due to the triggers of adolescent difficulties. Alison finds NSSH the most effective strategy for managing the intensity of the feelings and thoughts she is experiencing. The reason why the NSSH may not get worse is that Alison has people in her life who are willing to help, such as her parents and her teacher. Also, Alison has people she enjoys being with and activities she likes despite finding managing her expectations difficult.

As I pointed out in chapter five (pp. 136-141) Alison does not require an intervention that targets the NSSH.[104] Yet, this does not mean Alison does not require any intervention. In this case, perhaps, Alison would benefit from an intervention that targets her high

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[103] By being exposed to negative events Alison is given an opportunity to observe how the adults in her life respond and, perhaps, develop her skills. I am not saying that Alison needs to be exposed to unjust negative events, such as an oppressive society or abusive parents. Nor am I saying that Alison *must* be exposed to negative events to develop skills.

[104] This is not the version of Alison's case where she is engaging in NSSH in the classroom in front of others and exposing the cuts on her arms for others to see.

expectations of herself and her connection with her family. This is not to target the NSSH but, perhaps, these elements require intervention because they may have a long-term impact on her welfare. For instance, Alison has the concern that she does not feel like she fits into her family. Saying she does not fit into her family may imply she does not feel validated, supported or accepted by them; this would need to be explored by the clinician. A desire to fit in and belong to one's family is understandable because, generally, doing so helps one develop in many ways and creates a sense of worth. Fitting in with her family, then, would be an understandable desire for Alison to achieve for her welfare.[105]

Alison's case shows that what is of importance is to gain an understanding of her experience and what may be contributing to her engaging in NSSH. This is to determine whether to intervene and if an intervention is offered, what needs to be targeted. Gaining an understanding also allows a judgement to be made about whether to offer an intervention from a specialist, secondary mental health service.

Practical work

Claiming that having a mental disorder is neither necessary nor sufficient for warranting interventions from specialist, secondary mental health services, raises the need for practical work. This claim means that clinicians should not only provide interventions for those with a mental disorder. The work needing to be done, then, includes addressing policy questions about criteria for funding because access is no longer reliant on having a mental disorder. Furthermore, there is a need to change common mindsets. Work is needed to shift

[105] A clinical formulation for a real person would go into more depth and the intervention plan would be more detailed.

the judgement that only those with a mental disorder diagnosis deserve compassion. Plus, the view that having a mental disorder legitimises human suffering requires challenging.

Next, then, I ask the question: what are the necessary conditions for offering interventions from a specialist, secondary mental health service? I say more about my claim on welfare and offer ideas as an area for future research into the criteria to access these services.[106]

Necessary conditions for offering interventions from a specialist, secondary mental health service

I say that interventions should be offered only when they will advance the welfare of the service user. To say more about this claim and my ideas about other necessary conditions, let us consider the composite case of Luke, whom I presented in the introduction and chapter five. As a reminder, Luke is a 15-year-old male. He has arrived at the reception area of a specialist, secondary mental health service with a 9-inch chef's knife. He often threatens his peers and has been known to start physical fights. The fights often result in cuts and bruises to Luke and the other people involved. He has broken his finger once. He has attacked someone with a knife before too. On one occasion at school, he broke a window by throwing chairs. He has been suspended from school many times. He has been caught stealing loose change that he finds lying around. Occasionally, he has been out late with friends and he has broken house windows, scratched cars and spray-painted public benches. Luke's unruly behaviour, which has been occurring for many years, is having a negative impact on many

[106] Another area for future research, which I do not discuss, is the criteria for exiting these services. To put it another way, what should specialist, secondary mental health services aim to achieve but not go beyond?

areas of his life, such as the relationship with his parents, his peer relationships and his ability to gain an education. Luke warrants an intervention from a specialist, secondary mental health service.

Current and future negative outcomes

As pointed out in chapter five (pp. 114-116), Luke meets the diagnostic criteria for conduct disorder. Although on my view having a diagnosable mental disorder is not why he warrants an intervention, having the criteria already in place is helpful. Research shows that there are many negative outcomes to the unruly behaviour that meet the criteria for oppositional defiant disorder and conduct disorder. In chapter five (pp. 119-120) I have gone into detail about this research. As a brief reminder, Luke faces negative outcomes, such problems with many different relationships. Also, there is an increased risk of developing mental disorders, such as depression and anxiety, and (when an adult) a personality disorder. Other negative outcomes include criminal activity, involvement with gangs, being homeless, a low education standard, suicide, physical health problems, such as cardiovascular difficulties, and early mortality. In Luke's cases, his welfare, now and in the future, will be negatively impacted if an effective intervention that targets the unruly behaviour is not offered.

It is not, perhaps, only about Luke being better off, then, but counteracting current and future negative outcomes that lead to a large decrease in welfare. This is, perhaps, a large severe decrease in one important area of his life, such as only at home, school or when with his peers, or a less severe decrease across multiple areas of his life.

A blended account of welfare

Roache and Savulescu (2018) have a comparable view to mine. They advocate a welfare framework for psychiatry (Roache and Savulescu 2018, especially 248-257). They say:

> The advantage of welfarism over the current medical model is that it focuses on the central issue of welfare and asks: What is a mixed subjective/objective account of well-being in this person's case and what is the evidence that potential interventions (including biological, psychological, environmental) will have a favourable effect on that? (Roache and Savulescu 2018, 253-254).

Roache and Savulescu use a blended account of welfare, which I also offer here.

In philosophy, there are three dominant theories of welfare (see Bradley 2015 and Fletcher 2016 for helpful introductions). They are psychological state theories, desire-fulfilment theories, and objective list theories. Psychological state theories claim that only certain mental states are good for us, such as pleasure (hedonism), life-satisfaction and happiness. Desire-fulfilment theories claim that the fulfilment of our real or idealised desires is good for us, and nothing else is. Objective list theories say that reaching certain objective values is good for us. Psychological state theories and desire-fulfilment theories are subjective and objective list theories are (as the name indicates) objective.

There are benefits to using a blended account of welfare. Firstly, a subjective component of welfare allows for the consideration of a service user's psychological states and desires. To illustrate the benefit of including a subjective component, consider the hypothetical case of Annie presented in chapter five. Annie lives in an environment in which the societal norms are unjust and her unruliness is a response to those unjust norms. Annie lives in a society where females over the age of 14 years old are not legally allowed to continue gaining an education; instead, the societal norm is to gain employment. Annie's unruliness is understandable due to the injustice of being deprived of an education on the basis that she is female. Her desire to gain an education is understandable because, generally, gaining an education is done to develop important skills and knowledge. This appears to be an understandable desire for Annie to have, then; however, she is being prevented from

obtaining her goal due to an unjust society. Annie, then, requires an intervention that will change the unjust society she lives in; she requires an intervention directed at a wider change of the social circumstances, which is not offered by specialist, secondary mental health services.[107]

Secondly, there are benefits to having an objective component as part of an account of welfare. One benefit is that as Roache and Savulescu (2018, 250) say:

> Purely objective accounts of well-being are controversial, but there is good reason to take well-being to include an objective element. Amartya Sen has argued that taking well-being to consist solely in subjective assessments (i.e., in people's assessments of their own happiness) makes subjective accounts of well-being vulnerable to adaptive preferences: the phenomenon that people adjust their expectations to their circumstances, so that someone in deprived circumstances will expect less from life than someone in wealthier circumstances, and the two may give roughly similar subjective assessments of their well-being. Assuming that we believe that it is bad for people to live in deprived circumstances, this indicates that we should take into account more than people's subjective assessments when assessing their level of well-being.

There are benefits, then, to using a blended account of welfare.

A blended account of welfare for Luke

To illustrate how a blended account of welfare may apply to a composite case consider Luke again. Luke says he is happy with his life and he has no desire to stop being

[107] As another example, consider the composite case of Alison again who is engaged in NSSH. She has an understandable desire, which is a desire to fit in and belong to her family (pp. 158-160).

unruly because it makes him powerful. He says he enjoys fixing motorbikes, but he has no desire to attend a course on the topic because he thinks no one will employ him.

Although Luke is happy and has no desire to stop being unruly, it is not in his best interests to continue.[108] Luke is not getting on well with others, developing his abilities or being morally good. It is also not clear what knowledge he is gaining, whether he is satisfied with his life and whether it is rational to think that being unruly makes someone powerful. I suspect that many would agree that things like getting on well with others, developing one's abilities, being morally good, gaining knowledge, being satisfied with one's life and being rational are good for one's welfare.

When social welfare trumps individual welfare

A question for future research is whether interventions should be offered to advance social welfare rather than the welfare of the service user. For example, consider Luke's case again with an *unblended* account of welfare. A "psychological state theory of welfare" view may, perhaps, imply that Luke is a happy unruly youth, so I am saying that he warrants an intervention to stop him from harming others rather than to advance his welfare.

If it is accepted that social welfare may sometimes trump the welfare of the individual, this leads to the question of how to avoid the advancement of social welfare for unjust reasons. For example, consider again the hypothetical case of Annie, who lives in a society where females over the age of 14 years old are not legally allowed to continue gaining an education. Annie is displaying unruly behaviour and her unruliness is about the unjust society she lives in. In this case, the law is unjust. Rather than tackle this the government may

[108] When I say what does (or in this case what does not) advance one's "best interests" I am referring to advancing one's welfare.

say that there is a need to promote the welfare of others to justify an intervention to stop Annie being unruly.

Roache and Savulescu (2018, 255) say that the welfare of society may sometimes trump personal welfare. They point out that "Social welfare is placed above personal welfare" with the banning of smoking in certain places, preventing the parking of cars on busy streets, stopping loud music from being played late into the night in residential areas and with the use of quarantine (Roache and Savulescu, 2018 255). To guard against social welfare trumping personal welfare for unjust reasons they offer:

> categorizing the various possible goals of medicine, considering the circumstances under which it is appropriate to pursue them, and promoting the importance of these issues to clinical practice, would be steps toward ensuring that medicine is not used for illicit ends (Roache and Savulescu, 2018 255).

If it is accepted, then, that in some cases interventions should be offered to an individual for the benefit of others then this is an idea to explore in future research. In this future research it would be interesting to ask whether possible goals of medicine vary for children and youth compared with adults.

Adaptations to the environment

Another question for future research is whether it is permissible to sometimes offer an intervention to an individual rather than adapt their environment. For example, consider an unruly child in a classroom. Their behaviour includes running around the classroom, shouting out during the lesson and throwing paper planes. Their behaviour disrupts their learning and will result in a lower academic achievement. It is likely that if they were taught in an environment that included breaks every ten minutes and lots of physical activity their learning would not be negatively impacted. However, this type of learning environment is not available to this child. The environment is not available because the majority of children

would not be able to effectively learn in this environment, so the school schedule is designed to meet the needs of the majority. Also, the child's parents are unequipped to provide this environment through home schooling. I say that as their environment is not able to be adapted, in this case the child should be offered an intervention that targets the behaviour, allowing them to learn in the usual schooling environment. This is because the intervention will advance the welfare of the child.

If it is permissible to directly offer the child an intervention rather than adapt the environment, this raises the question of ensuring this is done without encouraging injustice. To illustrate this, consider a news article in the '*New York Times*' about a paediatrician, Michael Anderson (Schwarz 2012). Anderson is reported to be prescribing medication to children who are suffering from "poor academic performance in inadequate schools" (Schwarz 2012, para. 2). He says "We've decided as a society that it's too expensive to modify the kid's environment. So we have to modify the kid" (Schwarz 2012, para. 3). This example illustrates, then, that an analysis of why the environment is not being modified is required. In the reported case, the children are unjustly not being given access to an adequate school system. This is different from saying that the environment is practically not available to them. Further research, then, is needed to determine what principles to apply to say when the environment should and should not be modified.

Interventions offered by specialist, secondary mental health services

In chapter three (pp. 82-84) I outlined interventions offered and not offered by specialist, secondary mental health services. To summarise, I said interventions offered by specialist, secondary mental health services are delivered by someone with suitable and specialist training and qualifications in this field. The interventions may be offered within a variety of different settings. The interventions do not include a focus on changing social circumstances, such as tackling poverty.

The kind of intervention Luke warrants meets what I say is offered by specialist, secondary mental health services. In chapter five (pp. 120-121) I detailed the interventions Luke may benefit from. Luke requires a mixture of interventions, such as multisystemic therapy and individual therapy, that is best offered by those with suitable and specialist training and qualifications in this field. Luke warrants a complex package of specialist interventions that are best managed by clinicians who have suitable training. Furthermore, these clinicians are able to apply their knowledge to monitor Luke's presentation for other concerns like depression and anxiety, which he is at risk of developing. There is, perhaps, more to say about the kinds of interventions offered by specialist, secondary mental health services.

Persistence

A concern being persistent is, perhaps, necessary for it to qualify as warranting interventions from a specialist, secondary mental health service. It is difficult to give an exact measure of persistence. Perhaps to say a concern is persistent is to say the concern continues despite what has already been tried and based on the length of time that has passed. For example, Luke's parents may have tried different parenting strategies, yet the concerns continue. However, there may be cases that do not meet the condition of being persistent and still warrant an intervention because the problem is so severe. For instance, in Luke's case the current risk of significant harm to himself and others, and the high likelihood of negative outcomes indicate that he should warrant an intervention immediately, despite whether he meets this condition of persistence.

The efficiency of the intervention

Another idea for future research is related to the efficiency of the intervention. For this condition there is a need to analyse the costs and benefits of offering interventions. For

instance, a question may be this: should a costly and time-consuming intervention be offered if it only slightly advances a child or youth's welfare? To illustrate this question, consider Luke's case. Luke is being considered for an intervention package to target his unruly behaviour. His unruly behaviour has now continued for years, and the previous strategies and interventions that have been tried have not been successful. The behaviour is having a severe negative impact on his life and is very likely to continue having a negative impact. The intervention package involves a pharmacological intervention and a therapeutic group for Luke. Furthermore, Luke and his parents would live in a residential home with clinicians to offer a 24-hour intervention programme. In this case the intervention package being offered to Luke has been shown in research studies to only slightly increase the welfare of the child or youth. The question, then, would be this: should Luke be offered this costly and time-consuming intervention package if it may only slightly advance his welfare?

Summary

I claim the unruly behaviour in Luke's case warrants an intervention from a specialist, secondary mental health service. This is because offering Luke an intervention will advance his welfare.

However, there is more to say about this claim and my ideas about other necessary conditions. Luke's welfare, now and in the future, will be negatively impacted if an effective intervention that targets the unruly behaviour is not offered. Although Luke has no desire to stop being unruly, it is not in his best interests to continue. However, if an intervention was only being offered to stop him from harming others rather than to advance his welfare then, if this is acceptable, this raises the question of how to advance social welfare for just reasons. Luke's unruly behaviour would not be stopped if the environment is adapted. There is no need, then, to adapt the environment or ask whether it is permissible to offer him an

intervention rather than make an adaptation. He does not require an intervention directed at a wider change of social circumstances. The kind of intervention Luke warrants meets what I say is offered by specialist, secondary mental health services. In Luke's case the current risk of significant harm to himself and others, and the high likelihood of negative outcomes indicate that he should warrant an intervention immediately, despite whether he meets any condition of persistence. However, a question to ask is related to the efficiency of the intervention. For example, should Luke be offered a costly and time-consuming intervention package if it may only slightly advance his welfare? Hence, there is more philosophical work that needs to be done.

In summary, I say that interventions from a specialist, secondary mental health service should be offered only when they will advance the welfare of the service user. However, further research into whether sometimes social welfare trumps individual welfare may yield reason to add a clause to this condition. Furthermore, the condition is not sufficient. Hence, I have offered conditions and questions for future research.

Summary of my insights about mental disorder

In this dissertation I have offered some insights about mental disorder. My insights meet our intuitive understanding of mental disorder. I say that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are not mental disorders; that managing life in the best way one can with the abilities available at a particular stage of life is not disordered; and, furthermore, that whether one has a mental disorder should not determine whether one is offered interventions from specialist, secondary mental health services. Rather than saying what a mental disorder is, my insights tell us what it is not.

I should point out that I am not making any claims about positive mental health in this dissertation.[109] Philosophers have already pointed out that "well-being" (welfare) is often interchangeably used with "mental health" and is sometimes expressed as "mental well-being" (Keller 2019, 229). However, the philosopher Simon Keller (2019, 229) argues that "positive mental health is not identical to well-being". Instead, he says that positive mental health is instrumentally valuable "partly for its contribution to well-being" (Keller 2019, 232). The philosophers Sam Wren-Lewis and Anna Alexandrova distinguish positive mental health from well-being; however, they claim that positive mental health is necessary for well-being (Wren-Lewis and Alexandrova forthcoming cited in Keller 2019, 229 and 232). I am not committing to any claims into positive mental health at this stage. Further research is needed into the question of what mental health is and its relationship to well-being (see Murphy, Donovan and Smart 2020 for a critical survey of the literature).

I should also point out that all my cases are about children and youth. Yet, I have talked generally about some of my claims in this dissertation. For example, I say that interventions from a specialist, secondary mental health service should be offered only when they will advance the welfare of the *service user*. I have not said that when they will advance the welfare of the *child or youth*. Hence, someone may ask whether my general claims should only apply to children and youth. It would be an interesting piece of research to test my claims with adult examples.

I now explain why I am only offering all my insights to apply to mental disorders and not physical disorders.

[109] A positive definition of mental health says mental health is not only the absence of a disorder, but the presence of factors that connect to living a life that is going well.

Physical disorder

As pointed out by the philosopher Rachel Cooper (2013, 487-491), the distinction between mental and physical disorder is often only considered to be of secondary importance. Cooper (2013, 488) says "Academics interested in the concept of mental disorder have generally worried about the disorder part first, and the mental, if at all, only afterwards. The big problem has been taken to be how we might distinguish between the normal and the pathological". She points out:

> that although the correct account of disorder is contested, all accounts that are currently being developed can apply equally to both mental and physical disorders. As such any distinction that can be drawn between mental and physical disorders will not simply emerge naturally out of a satisfactory account of disorder. Rather, even if a satisfactory account of disorder is developed, the problem of working out how mental and physical disorders can be distinguished will remain a separate task (Cooper 2013, 490).

This raises the question of why I am only offering insights about mental disorder.

Further work is needed to analyse whether my insights apply to the physical domain. For example, an interesting question to explore is whether physical states that are usually part of a passing phase and produce goods appropriate to that phase of life are physical disorders. I have no objections to someone wanting to apply my insights to physical disorders because I recognise there may be similarities with mental and physical disorders; yet, broadly, there is an important difference.

Disorder of the brain

Mental disorders are not linked to a specific problem in a body part or process. Physical disorders, for example diabetes, are linked to a specific problem with the body.

There are different types of diabetes. Those who have type 1 diabetes have a pancreas that produces very little or no insulin. Insulin is needed by the body to use glucose. If someone has type 2 diabetes either their pancreas does not produce enough insulin or the body's cells do not recognise the insulin. Everyone with diabetes will have the same problem with the same body part or process. Yet, not everyone with a mental disorder, such as anxiety, depression, bipolar or schizophrenia, has the same problem with a body part or process.

In response, someone may say that broadly mental disorders do share the same physiological problem: a problem originating in the brain. This is a prevailing view; however, despite there being significant advances in the fields of neurodevelopment, genetics and neuroscience, no specific physiological biomarkers are used for predominant mental disorders. The claim that mental disorders are brain disorders would be proven by reputable publications, and evidence in practice, such as the routine use of blood tests or scans to diagnose mental disorders. Yet, this research and clinical evidence does not exist. Hence, the claim that mental disorders are a problem with the brain has not been proven.[110]

Despite the lack of evidence to prove the claim that mental disorders are a problem with the brain let us pause and ponder if this view will ever be helpful. The reason I am of the opinion that it is important to contemplate the helpfulness of this view is that my project is driven by the practical goal of improving mental health care.

Imagine that we have a complete picture of how different areas of the brain function and how the brain connects. Now three people go to see a clinician with a scan of their brain

[110] I do recognise that there are physiological causes for mental states, and there may be changes in the brain due to having a mental disorder. Furthermore, physiological interventions, such as pharmacological interventions, are sometimes effective. However, there is no evidence that mental disorders are brain disorders.

that shows an absence in a particular structural part. The brain map indicates this absence is connected to experiencing shame and guilt. Person A tells the clinician that their experiences of guilt and shame are because they live a lavish life and others tell them they should help those who are worse off. They say their suffering is due to the comments their friends make about them. Person B explains they are experiencing guilt and shame because they are in an abusive relationship. Their suffering is due to the emotional abuse and is perpetuated by the societal view that those being abused should simply leave their partners. Person C explains that they have only come to see the clinician on the advice of their doctor who discovered the absence in their brain during a routine test. Person C says that they do have thoughts of guilt and shame about their life, but their loved ones help them manage, so they are not suffering.

With this hypothetical situation, the intervention would be different for each person even though they are presenting with the same structural absence in their brain. Perhaps person A needs to give to those in need through voluntary work or obtain a new circle of friends who do not make them feel guilty for being rich. Person B may need to separate from their partner, have therapy to overcome the impact of the abuse and no longer experience the victim-blaming societal view.[111] Finally, it is likely that Person C does not require an intervention.

Simplistically requiring a different intervention is no different for physical disorders. For instance, people with type 2 diabetes require different interventions despite having the same physiological problem. The range of interventions includes insulin injections,

[111] I recognise that some prefer not to use the term "victim" because this may be perceived as disempowering. Furthermore, some say that the perpetuator may be a (historical) victim because they have experienced historical abuse. I use the term "victim-blaming" because this is commonly used by society.

medication to lower the glucose in the body and increase the body's cells sensitivity to insulin, dietary changes alongside an increase in exercise, or a combination of interventions. Yet, for physical disorders the different intervention is still targeted at treating the same body part or process. What clinicians treating physical disorders, such as diabetes, need to know is whether the invention offered manages the particular problem with the body part or process. For mental disorders this is different. Even with a map of the brain, there is no moving away from the need to understand the experience of the individual's thoughts, emotions and behaviours alongside the environment they live within and the relationships they have. Hence, even if there is a universal contributory problem in a physiological part, such as the brain, the person's environment and relationships in one's life still need to be considered when determining the problem.

Practical motivations

I recognise that there are practical motivations for wanting to consider phenomena as physical brain disorders rather than mental disorders. For example, Cooper (2013, 491-495) discusses the likely motivations for claiming that Tourette's Syndrome and Myalgic Encephalomyelitis (M.E.) are physical disorders. I am not going to make a claim about whether these disorders are physical or mental.[112] Instead, I am using Cooper's discussion to draw out some practical motivations.

[112] Cooper (2013, 493) notes that "Patient groups frequently prefer terms that are suggestive of a biological cause—myalgic encephalomyelitis (in the U.K.) or chronic fatigue immune dysfunction (in the U.S). In contrast, chronic fatigue syndrome, frequently used by medics, has no overtones of organicity". I assume a "biological cause" means a physiological cause. I am using the term M.E. because it is one of the preferred terms. For my purposes there is no need to make a claim about the cause of M.E.

Firstly, one practical motivation for viewing mental disorders as physical disorders is may be to avoid unjust blame. When discussing Tourette's Syndrome, Cooper (2013, 492) says:

> At the personal level it is common to find patients and their parents speak of their "relief" at hearing that Tourette's is a physical disorder. In part, to claim that Tourette's is a physical disorder is to make a claim about what it is not. For some, a physical disorder is specifically not the sort of condition that can be explained by psychoanalytic theory, or by other psychological models that trace disordered behaviour to faulty upbringing. Many parents and patients can recall unhappy experiences with psychoanalysts in the seventies and eighties. One mother recalls "the really tragic part of it was that the psychiatrists we went to would all blame me for Bill's problems. Right in front of me, they would ask him, 'what has your mother been doing to you'" . . . To claim that Tourette's is physical rather than mental is to claim that no-one—neither the child–patient, nor their parents—can be blamed for it.

The same motivation may apply to other disorders. For instance, suggesting that someone with depression has a chemical imbalance in the brain may mean that the person with depression and their parents avoid blame.

I should highlight that the above quote from Cooper (2013, 492) discusses the experiences of perceived blame from clinicians. This is not to single out clinicians as there is a wider society view of blame that may motivate some to want to view mental disorders as physical disorders of the brain.

Yet, not all physical disorders are completely immune from eliciting blame. For example, some may have the view that smokers who develop lung cancer are to blame.[113] Jyoti Patel (2014, para. 1), an oncologist, says "For years I have cared for patients with lung cancer who suffered from the stigma surrounding the disease . . . They, and many others, felt the disease was somehow self-inflicted. They felt guilty for putting their loved ones through such a difficult journey, one they felt they had brought upon themselves". There are other cases. For instance, cases of HIV and diabetes may elicit blame. Perhaps, some may blame someone who contracted HIV through sex but not someone who was diagnosed after a blood transfusion. Furthermore, some may blame those who are overweight for developing diabetes. If a child has diabetes then their parents may incur the blame for providing them with a diet high in fat and sugar, and for allowing a sedentary lifestyle. A parent may also blame themselves for passing on their genes, which they believe has now resulted in their child developing the condition. However, as with mental disorders, the development of physical disorders is complex and living in an environment of blame will not aid people to get the help and support they need.

Further practical work is, then, needed. Some clinicians in both the physical and mental domains need to work on delivering assessment and intervention tools in a way that avoids unjust blame. Furthermore, when individual factors, such as poor parenting, are partially contributing to any disorder then this needs to be explained and resolved sensitively. Additionally, there needs to be a change in the societal perception of blame.

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[113] Cooper (2103, 496) is making a different point, but she also uses the example of lung cancer. Her point is that with physical disorders there is a moralising about the cause of the disorder and with mental disorders it is unclear "whether the condition itself is a disorder or a vice" (Cooper 2013, 496).

Secondly, a practical motivation for viewing mental disorders as physical disorders may be to ensure proper access to effective adjustments to the environment and economic cover. For instance, Cooper (2013, 492-493) points out that given the "limited number of categories of disability" how children are classified will impact what adjustments are made for them in the school environment. A further example, provided by Cooper (2013, 494), is that insurance companies in the United States of America pay less for mental disorders.[114] However, if people are being negatively affected by policies and structures then this should be practically addressed.

Thirdly, a practical motivation for viewing mental disorders as physical disorders may be to legitimise the disorder. As Cooper (2013, 495) says "Given that society treats mental disorders as only being dubiously disorders, it is understandable that patients with [M.E.] hear suggestions that the condition may be psychological as being dangerously close to claiming that it is unreal". This may be the case for other phenomena. Due to mental disorders being viewed with suspicion there is a motivation to, instead, consider them as physical disorders. Further practical work, then, is needed to change this mindset so that having a mental disorder is thought of as legitimate.

An additional practical motivation

I draw upon my clinical experience for the last feasible practical motivation. Another reason why someone may want to consider themselves to have a physical brain disorder, rather than a mental disorder, is to avoid any negative impact on how they view themselves. To illustrate this influence, consider the first-person narrative of Karen (2018, para. 1-5):

[114] Cooper (2013, 494) does point out that this is less of a problem now.

> I feel like I've lost a lot of things to depression: time, energy, motivation. But none of these compares with the feeling that I lose myself and my identity when I'm depressed.
>
> I've always been an over-achiever and a perfectionist. I would go above and beyond to help people. I rarely missed a day at my job. I was the responsible one and the one other people could count on. Except when I was depressed.
>
> On the days when I was depressed, I could barely find enough motivation to take a shower. Achieving everyday things was difficult. Getting myself out the door to work felt almost impossible. Taking care of other people was almost out of the question because I could hardly take care of myself.
>
> As the days of depression stretched on into weeks and months and years, it felt like I had lost the person I thought I was. I was the perfectionist, but now I couldn't care about anything enough to worry whether it was perfect or not.
>
> Who was I? How could depression change me so much? Would I ever be 'myself' again?

In this excerpt, from a mental discrimination campaign website, Karen describes how having depression has made her question who she is.

She goes on to explain that she has come to some resolution with this questioning. Karen (2018, para. 9-11) says:

> opening up about my depression and letting other people see the real me was one of the best things I could have done. The burden of secrecy was gone, and I found that the people closest to me were willing to support me through my depression . . .
>
> I wish I could say that all of this made my depression go away, but it didn't . . . The most important thing for me, though, is what I learned about my identity.

> Depression takes a lot away from people and that includes a sense of self. I lost who I was through my depression and felt guilty for it. But it wasn't my fault. Just like other diseases might take away someone's ability to go on with life like they used to, depression takes away my ability to act like the person I'm used to being. My real self is still there, somewhere underneath my depressed self. Depression does not define who I am.

Hence, Karen says being open with others has helped, but depression still impacts on how she views herself.

From my clinical experience, some people attempt to come to some resolution of the change in the view of themselves by considering mental disorders to be physical brain disorders. The problem then is in a physiological organ, which someone is able to detach from; rather than the problem being in one's thoughts, emotions or behaviour. When the problem is in one's thoughts, emotions or behaviour it is much more difficult to not question who you are. I am sympathetic when individuals are motivated to view themselves as having a physical brain disorder to avoid any negative influence on how they view themselves, but I have worries about this approach.

Worries with the additional practical motivation

Viewing oneself as having a physical brain disorder to avoid any negative impact on how one views themselves raises worries. I will sketch two worries to start with. Further work is needed to analyse and make an argument for these worries.

Firstly, let me say why I am not convinced that this approach will be helpful. I am not convinced because some have negative views of themselves due to having a physical disorder. To illustrate how, consider an excerpt from an online blog on the website for '*Children's National*', a paediatric service in the United States of America. The blog is

written by Eleanor Mackey, a child psychologist, and is aimed at parents and carers of children with diabetes. She says:

> Despite families' best efforts, diabetes can feel very defining to kids. Often, teachers and peers may treat them as different, even if well-meaning. For example, a teacher may set aside a different snack for a diabetic child than the rest of the class. Rightfully concerned parents often ask, 'Did you check your blood sugar?' before asking how their child's day went.
>
> Sleepovers, school trips, and birthday parties all require more thought and parental involvement for children with diabetes than for their peers. Therefore, children may begin to feel defined by their illness and this can cause some children to feel bad about themselves.
>
> Also, it is important to understand that diabetes is very difficult to manage. It can be hard to achieve the target blood sugar levels and a lot of factors outside a child and family's control can make this more difficult. Children who are struggling to manage their diabetes might feel a profound sense of failure, which is often accompanied by concern and frustration by their families and medical teams (Mackey 2014, para.4-6).

These comments illustrate that children with diabetes may have a negative view of themselves, which may develop due to being treated differently, being perceived as needing extra consideration and not be able to manage their physical disorder. Having a physical disorder, such as diabetes, may influence how someone views themselves. Unlike a mental disorder, the change of view in oneself is, perhaps, not about one's thoughts, emotions or behaviour, but there is a change of view. This is, perhaps, what Karen (2018, para.11) means by the line "Just like other diseases might take away someone's ability to go on with life like they used to, depression takes away my ability to act like the person I'm used to being".

Hence, I am not convinced that viewing mental disorders as physical disorders will completely avoid a negative impact on how one views oneself.

Secondly, I have a concern that the motivation to view mental disorders as physical brain disorders to avoid any negative impact on how one views themselves may, unintentionally, perpetuate problematic disorder comparisons.

"Disorder comparisons" are when one disorder or group of disorders is commonly compared to another.[115] For example, imagine you are feeling upset about living with a chronic disorder, such as diabetes, so you seek comfort from a friend. Your friend makes a "disorder comparison" when they tell you that things may be worse for you if you had a disorder such as Parkinson's disease. Your friend is comparing living with diabetes with living with Parkinson's disease. In another example, consider a piece in '*The Spectator*' written by Max Pemberton, a doctor. Pemberton (2015, para.4) says "As a doctor I can tell you that, medically speaking, I'd rather have HIV than diabetes". He goes on to describe how things, such as the risk of developing other disorders, are worse for those with type 2 diabetes than for those with HIV. He is comparing type 2 diabetes with HIV to argue that HIV is no longer the death sentence it once was considered to be.

Disorder comparisons are problematic. My concern with disorder comparisons is that the individuals behind the comparisons are forgotten. For instance, when the friend says that Parkinson's disease is worse than diabetes there is an unintentional risk that people with Parkinson's disease may be looked down upon and pitied. Likewise, the doctor comparing HIV with type 2 diabetes may inadvertently paint a hopeless and bleak picture of those living

[115] In parts of this discussion I use my public opinion piece titled '*So you've just been diagnosed with a chronic illness?*' (Ahir-Knight 2019).

with type 2 diabetes. Similarly, viewing oneself as having a physical brain disorder may accidentally imply that those with mental disorders are in a worse situation.

A further concern I have with disorder comparisons is that they may, unintentionally, minimise the perceived suffering of someone. For example, the friend comparing Parkinson's disease with diabetes is assuming that the suffering of people with diabetes is less than those with Parkinson's disease. Also, the doctor comparing HIV with type 2 diabetes and arguing that type 2 diabetes is medically worse avoids pointing out how living with HIV may be harsher depending on what the person values. For instance, someone with HIV may experience being ostracised more and this is what causes their suffering. Furthermore, having the view one would rather have a physical disorder, such as a brain disorder, than a mental disorder may, inadvertently, imply that those with physical disorders do not deeply suffer. This is because one would trade their mental disorder for a physical disorder rather than recognise that all disorders have the potential to cause profound suffering. Hence, I have worries with the practical motivation of considering oneself to have a physical brain disorder to avoid any negative impact on how one views themselves.

Summary

I only apply my insights to mental disorders because further work is needed to see whether my insights apply to the physical domain. My insights aim to have practical implications, so I have pointed out an important difference between mental and physical disorders. This difference means that I am not offering my insights to apply to physical disorders. I recognise there are practical motivations for viewing mental disorders as physical disorders but, hopefully, these motivations can be met in other ways to avoid the worries I raise.

I now end by discussing an overarching theme of this dissertation.

Making progress without committing to a definition or theory of mental disorder

In this dissertation, I have made significant philosophical progress in thinking about mental disorder and interventions without committing to a particular definition or theory of mental disorder. Without taking a stance on a definition of disorder, I have argued that NSSH in youth is never a mental disorder in its own right. I made my argument by using my strategy of argument by comparison. This means progress can be made even when there is disagreement about what mental disorder is and vagueness about how to apply a definition. Furthermore, I have claimed that having a mental disorder is not necessary for warranting interventions from a specialist, secondary mental health service, and I have shown that on *any* plausible theory or definition of disorder, it is not the case that all those with mental disorders should always be offered interventions from these services. I have made this claim without committing to any particular theory or definition of mental disorder. Progress, then, can be made while theories and definitions are still being developed. My approach of not committing to a particular definition or theory is a contribution to the philosophical discussion of mental disorder because it shows that there is another method to use.

Conclusion

In conclusion, I offer to the philosophical discussion my insights about mental disorder, and the method of not committing to a particular definition or theory of mental disorder to make progress. I say that behaviours and thoughts that are usually part of a passing phase and produce goods appropriate to that phase of life are not mental disorders; that managing life in the best way one can with the abilities available at a particular stage of life is not disordered; and, furthermore, that whether one has a mental disorder should not determine whether one is offered interventions from specialist, secondary mental health

services. Finally, I say that instead of having a mental disorder, interventions should be offered only when they will advance the welfare of the service user.

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Appendix one: background and terminology

Age ranges

There are different age ranges assigned to the term 'child' and 'youth'. For this dissertation, the "child" age range is from birth to less than 10 years old and the "youth" age range is from 10 to less than 25 years old. "Adults" are 25 years old and above.

"Disorder"

In the mental and physical health literature, and from my clinical experience some distinguish between "illness", "disease", "condition", "disorder" and other similar terms. However, in this dissertation, the term "disorder" covers all these different terms.

I identify behavioural disorder under "mental disorder". My reason for this is to ensure my discussion captures all disorders that require mental and behavioural intervention. For example, some may say that alcoholism is a behavioural disorder, not a mental disorder; they perhaps say this because a behavioural approach is taken when considering intervention. At this theoretical level, it is easier to capture all under the term "mental disorder".

DSM-5 and ICD-11

The '*Diagnostic and Statistical Manual*' (DSM-5), developed by the American Psychiatric Association, and the '*International Classification of Diseases*' (ICD-11), developed by the World Health Organization, are classification frameworks. These frameworks are often referred to in the practice of mental health. The manuals list symptoms, mental states or behaviours that when added up together, usually over a period of time or having occurred a certain number of times, results in a diagnosis.

Genders

In this dissertation I use “he”, “she” and “they” as individual gender terms. I have done this to reflect the range of genders.

“Parents”

I recognise that someone with legal parental responsibilities may be a parent, carer or the state. All these different people and agencies have a parenting role, so I collectively refer to them in this dissertation as “parents”. Furthermore, I recognise that a child may have one person acting as a parent, so the use of the plural is for consistency in my writing only.

Appendix two: detailed diagnostic criteria for oppositional defiant disorder and conduct disorder

This appendix is reference material for the ICD-11 and DMS-5 diagnostic criteria for "oppositional defiant disorder" (hereafter referred to as "ODD") and "conduct disorder".

In the ICD-11 (World Health Organization 2019), under the heading *'Mental, behavioural or neurodevelopmental disorders*' is the category '*Disruptive behaviour or dissocial disorders*' (section 6). The description for this category is:

> Disruptive behaviour and dissocial disorders are characterized by persistent behaviour problems that range from markedly and persistently defiant, disobedient, provocative or spiteful (i.e., disruptive) behaviours to those that persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws (i.e., dissocial). Onset of Disruptive and dissocial disorders is commonly, though not always, during childhood (World Health Organization 2019, section 6).

This category groups together ODD and conduct disorder. For both disorders there are sub-classifications. For example, ODD may be classified as having a chronic level of irritability and anger, and conduct disorder may be classified as starting in childhood or adolescence.

In the DSM-5 (American Psychiatric Association 2013) ODD and conduct disorder are placed under the category of '*Disruptive, Impulse-Control, and Conduct Disorders*' (section II). This chapter of the DSM-5 (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*') is acknowledged by the authors as being "unique" because the disorders here, while problems of self-control of emotions and behaviours, manifest in ways that "violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or

authority figures". The authors also recognise that the symptoms of these disorders are part of typical development. The authors say:

> it is critical that the frequency, persistence, pervasiveness across situations, and impairment associated with the behaviors indicative of the diagnosis be considered relative to what is normative for a person's age, gender, and culture when determining if they are symptomatic of a disorder (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*').

The authors also state that these two disorders rarely first emerge in adulthood.

ICD-11 diagnostic criteria: oppositional defiant disorder

Firstly, here are the diagnostic criteria for ODD in the ICD-11. The ICD-11 (World Health Organization 2019, section 6) says:

> Oppositional defiant disorder is a persistent pattern (e.g., 6 months or more) of markedly defiant, disobedient, provocative or spiteful behaviour that occurs more frequently than is typically observed in individuals of comparable age and developmental level and that is not restricted to interaction with siblings. Oppositional defiant disorder may be manifest in prevailing, persistent angry or irritable mood, often accompanied by severe temper outbursts or in headstrong, argumentative and defiant behaviour. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

DSM-5 diagnostic criteria: oppositional defiant disorder

The diagnostic criteria in the DSM-5 (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*') for ODD are:

A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

Argumentative/Defiant Behavior

4. Often argues with authority figures or, for children and adolescents, with adults
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months.

Note: The persistence and frequency of these behaviours should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

Specify current severity:

Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).

Moderate: Some symptoms are present in at least two settings.

Severe: Some symptoms are present in three or more settings.

ICD-11 diagnostic criteria: conduct disorder

Here are the diagnostic criteria for conduct disorder in the ICD-11. The ICD-11 (World Health Organization 2019, section 6) says:

> Conduct-dissocial disorder is characterized by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules, or laws are violated such as aggression towards people or animals; destruction of property; deceitfulness or theft; and serious violations of rules. The behaviour pattern is of sufficient severity to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. To be diagnosed, the behaviour pattern must be enduring over a significant period of time

(e.g., 12 months or more). Isolated dissocial or criminal acts are thus not in themselves grounds for the diagnosis.

Finally, here are the diagnostic criteria for conduct disorder in the DSM-5.

DSM-5 diagnostic criteria: conduct disorder

The diagnostic criteria in the DSM-5 (American Psychiatric Association 2013, section II '*Disruptive, Impulse-Control, and Conduct Disorders*') for conduct disorder are:

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 at least three of the following 15 criteria in the past 12 months from any of the categories below, 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 the 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.

Specify whether:

312.81 (F91.1) Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years.

312.82 (F91.2) Adolescent-onset type: Individuals show no symptom characteristic of conduct disorder prior to age 10 years.

312.89 (F91.9) Unspecified onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.

Specify if:

With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers).

Lack of remorse or guilt: Does not feel bad or guilty when he or she does something wrong (exclude remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules.

Callous-lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others.

Unconcerned about performance: Does not show concern about poor/problematic performance at school, at work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance.

Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions "on" or "off" quickly) or when emotional

expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others).

Specify current severity:

Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking).

Moderate: The number of conduct problems and the effect on others are intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism).

Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).