Safeguarding against the medical treatment of homosexuality

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Abstract

In the past, homosexuality, masturbation, being a runaway slave and being a political dissident have all been considered to be mental disorders and medically treated on this basis. The medical treatment of these conditions seems to be an example in which psychiatry has been used as a guise for social control. If the medical treatment of these conditions can be safeguarded against, then future misuses of psychiatric treatment might also be safeguarded against.

This thesis considers whether the misuse of medical treatment of these and other conditions can be safeguarded against by showing that the following two criteria are fulfilled:

1. Only mental disorders may be medically treated on the basis of being mental disorders, and
2. These conditions are not mental disorders in any society.

The thesis shows that there is a pragmatic (*c.f.* prescriptive) link between the way the concept *mental disorder* is ordinarily used and medical treatment, and so the first criterion is fulfilled. For the second criterion to be true, it needs to be shown that the extension of mental disorder is:

2.1 Static between societies, and
2.2 Excludes homosexuality, masturbation, being a runaway slave and being a political dissident.

Three potential ways of achieving both 2.1 and 2.2 are considered – basing the extension of *mental disorder* on ordinary language, natural kinds or evaluations.

Firstly, the way *mental disorder* is ordinarily used by health professionals and informed lay-people in the developed world does exclude homosexuality and the other conditions mentioned earlier. However, ordinary language does not make the extension of *mental disorder* static between societies, and so does not fulfil criterion 2.1.

Secondly, the ordinary use of *mental disorder* does not pick out a natural kind, so the extension of *mental disorder* cannot be fixed in this sense. If *dysfunction* (being a component of *mental disorder*) picks out a natural kind, then the extension of *mental*

disorder might be partly static i.e. criterion 2.1 might be fulfilled. However, it is shown (using revisionist and conservative naturalism) that if criterion 2.1 is met, then criterion 2.2 cannot be met and *vice versa.* This applies whether *dysfunction* picks out a family resemblance natural kind or an essentialist natural kind.

Thirdly, as disvalue is a necessary component of the ordinary sense of *mental disorder* (as used by health professionals and informed lay-people), there might be Rawlsian primary goods concerning the extension of *mental disorder.* While Graham's (2013) basic psychological capacities might be primary goods, their expansiveness means that they are highly unlikely to fix the extension of *mental disorder* i.e. meet criterion 2.1.

As none of these approaches fulfil both components of the second criterion, the thesis has not shown that the medical treatment of homosexuality, masturbation, being a runaway slave and being a political dissident can be safeguarded against by showing, for once and for all, that they are not mental disorders.

Acknowledgements

With the benefit of hindsight, I recognise that when I started this thesis, my thinking was very philosophically naïve. It is with the help of my friends and colleagues at the Bioethics Centre, especially my supervisors Dr. Neil Pickering and Prof. John McMillan, that my philosophy has become (hopefully) less naïve. Thank you for giving me the time and guidance to help to carve out a more sophisticated philosophical stance.

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Chapter One - Introduction

1. Mental disorder and medical treatment

Homosexuality is not ordinarily considered to be a mental disorder by health professionals and informed lay-people in the developed world.[1] As a millennial, who grew up in the western world and was raised by a liberal family, it is bizarre to think that homosexuality was classified as a mental disorder in the American Psychiatric Association's *Diagnostic and Statistical Manual* (henceforth, the *DSM*) until 1974 (Rubinstein, 1995; Spitzer, 1981). However, homosexuality was considered to be a mental disorder in the past and is still considered to be a mental disorder in some parts of the world, such as China[2], Serbia [3] and Indonesia.[4] Other sections of society also classify homosexuality as a mental disorder, such as the National Association for Research and Therapy of Homosexuality (NARTH)[5], some fundamentalist Christians and orthodox Jews (see Halper & Price, in Earp *et al.*, 2014).[6] This thesis considers whether those people or societies that consider homosexuality to be a mental disorder are wrong. However, the scope of this thesis is not limited to whether homosexuality is a mental disorder. While it seems abhorrent to those of us in the developed world to call masturbation, being a runaway slave and being a political dissident mental disorders, in the past all these conditions have been considered to be mental disorders. [7] Hence, this

[1] By 'developed world', I do not mean the current western world, as there are still some people in the West who consider homosexuality to be a mental disorder.
[2] Human Rights Watch (2017), see also BBC (2017).
[3] In 2008, 70% of people living in Serbia considered homosexuality to be a mental disorder (Blagojević, 2011).
[4] More precisely, the Indonesian Psychiatric Association still considers homosexuality to be a mental disorder (Yosephine, 2016).
[5] NARTH argue that homosexuality is a developmental disorder (Nicolosi and Nicolosi, 2012, 12). Joseph Nicolosi, who until his death in 2017, was the director of NARTH claimed that there are no gay people (teenagers, to be specific). Instead, he claimed that there are only heterosexual people with a homosexual problem i.e. a developmental disorder (Nicolosi and Nicolosi, 2012, 173).
[6] On the 6th February 2018, the London cinema Vue cancelled the screening of the film 'Voices of the Silenced', which supports therapy to make gay people straight. The film was supported by the Core Issues Trust; a Christian group who support men and women with homosexual issues who voluntarily seek change in sexual preference and expression (BBC, 2018). This has not been used as an example of a group of people that consider homosexuality to be a mental disorder because Dr. Mike Davidson, of the Core Issues Trust, says that the Trust considers homosexuality to be a 'normal developmental aberration' as opposed to a disease. However, Dr. Davidson does not explain the difference between diseases (i.e. disorders) and aberrations (Moreton, 2012). Nonetheless, the cancellation of the screening does suggest that the medical treatment of homosexuality is looked down upon.
[7] 'Condition' is used as a neutral term to pick our states that might potentially be mental disorders.

thesis asks whether the extension (i.e. scope[8]) of *mental disorder* excludes all those conditions we, in the developed world, do not consider to be mental disorders,[9] and whether this extension can be applied in all societies.[10] This question has two components. Firstly, is there an extension of *mental disorder* that is static between societies i.e. an extension of *mental disorder* that applies in all, even in those societies that do not recognise or dispute the extension? (Section two of this chapter explains why the thesis asks whether there is a static extension of *mental disorder*, as opposed to whether there is a true extension thereof.) Secondly, does this static extension (presuming it exists) exclude all those things we (as health professionals and informed lay-people from the present-day West) do not consider to be mental disorders? If both these criteria are true, then those who consider homosexuality (or masturbation, being a runaway slave or being a political dissident) a mental disorder are wrong. It is not simply the case that these societies use an extension of *mental disorder* that is different to that used in the developed world – their extension would be wrong. I am not the first person to consider whether the extension of *mental disorder* is fixed between societies. Brülde puts the problem in the following way:

> Assume that A and B, two physicians (medicine men, or the like) that belong to different cultures, disagree on whether a certain person P is ill or not, and that they both apply the criteria of their own culture correctly. P is deceitful, impulsive, aggressive, reckless, and irresponsible, and A thinks that he suffers from a mental disorder (Antisocial Personality Disorder), whereas B thinks he is simply a troublesome and disturbing character. In cases like this, is one of the parties right while the other is wrong, i.e. do questions of the form "Is P ill or not?" have determinate answers? Or can they both be right?" Does it matter if P belongs to A's or B's culture? (Brülde, 2005, 2).[11]

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[8] The extension of a concept is a list of all the members of the kind. For example, the extension of *bachelor* is all the bachelors e.g. Brad Pitt, Tom Cruise and so on. The intension of a concept refers to the meaning of a concept. For example, the intension of bachelor is that all bachelors are male, unmarried and adults. This example is not intended to suggest that all concepts can be defined essentially i.e. in terms of necessary and sufficient elements.

[9] Pragmatic accounts of *mental disorder* may be able to show that conditions such as homosexuality are not mental disorders (see Zachar, 2002; Agich, 1997; Phillips *et. al*. 2012. This thesis does not consider pragmatic accounts of *mental disorder* due to space and constraints, and the fact that pragmatic accounts are unlikely to be able to fix the extension of *mental disorder* between societies.

[10] When referring to a concept (such as the concept of *mental disorder*), the term is italicised. When not referring to the concept but the thing itself, the term is not italicised. See section two of this chapter.

[11] Nordenfelt also uses this approach – he introduces person C, who exhibits extreme behaviour which suggests that C thinks he is in contact with god. A physician determines that C is ill (i.e. disordered), whereas a Pentecostal pastor says that C is not ill, but is temporarily out of contact with the world around him (Nordenfelt, 1995, 10). Nordenfelt does not use this scenario to ask whether there is a single, correct conception of illness) but uses it to show that the physician judges C to be ill while the pastor does not because they are considering C from different contexts.

Brülde's scenario can be adapted to be relevant to homosexuality. That is, a health professional from one culture might claim that homosexuality is a mental disorder while a health professional from the developed world will disagree. Both health professionals apply the criteria for mental disorder of their own culture correctly. Is one health professional right, and the other wrong? Or is it possible that both health professionals are right?

Why does it matter whether homosexuality falls within the extension of *mental disorder*? This thesis shows that there is a pragmatic link between mental disorder and medical treatment such that if a condition is considered to be a mental disorder, then medical treatment is appropriate.[12] This link does not mean that all and only mental disorders should be medically treated. That is, there is no exclusive prescriptive link between mental disorder and medical treatment. Instead, the pragmatic link refers to the idea that it makes sense to medically treat mental disorders because both medical treatment and mental disorders fall within the Asclepian frame.[13] Returning to the question of why it matters whether homosexuality is a mental disorder, the existence of the pragmatic link means that if homosexuality is a mental disorder, then the medical treatment of homosexuality is appropriate. (To be clear, this does not mean that medical treatment of homosexuality should be provided.) For example, in China, from 2009 to 2017, there were seventeen cases of forced conversion therapy, including shock therapy.[14] While homosexuality was removed from the Chinese Society of Psychiatrist's list of mental disorders in 2001, in practice, homosexuality is still treated on China on the basis of being a mental disorder (Human Rights Watch, 2017). As homosexuality is, in practice, considered to be a mental disorder in China, this conversion therapy is appropriate (*c.f.* acceptable). The link between mental disorder and medical treatment means that in those societies in which homosexuality is considered to be a mental disorder, the rhetoric of mental disorder can be used to show that the medical

[12] *C.f.* considered to be appropriate. 'Considered' is not required because, as will be shown in section four of chapter four, there is a pragmatic link between a condition being considered a mental disorder and whether medical treatment is actually appropriate.
[13] The pragmatic link also exists between medical treatment and physical disorders. However, mental disorders are the focus of this thesis.
[14] Human Rights Watch (2017). See also BBC (2017).
Conversion therapy is a generic term to describe medical treatment, such as shock or aversion therapies, in which a gay person is treated with the aim of making him or her straight.

treatment of homosexuality is appropriate. That is, the medical treatment of homosexuality is appropriate on the basis that homosexuality is a mental disorder.

The rhetoric of disorder cannot be used to show that non-disorders may be medically treated – only disorders may be medically treated on the basis of being disorders. If the extension of *mental disorder* is both static and excludes homosexuality, then those societies that consider homosexuality to be a mental disorder are wrong. In turn, those societies that medically treat homosexuality on the basis that it is a mental disorder have incorrectly applied the rhetoric of mental disorder. That is, such a society uses an incorrect extension of *mental disorder,* but the rhetoric (i.e. the pragmatic link) is correctly applied. To safeguard against the medical treatment of homosexuality (on the basis that is it not a mental disorder), it is insufficient to show that those who consider homosexuality to be a mental disorder use an extension of *mental disorder* that is different to that used in the developed world. It must be shown that extensions of *mental disorder* that include homosexuality are wrong. If it can be shown that those who claim that homosexuality is a mental disorder' are wrong, then the medical treatment of homosexuality could be safeguarded against. This method does not show that homosexuality may never be medically treated. However, if successful, it would show that homosexuality may not be medically treated on the basis of being a mental disorder. For this reason, I do not ask whether this approach will 'prevent' the medical treatment of homosexuality, but whether it will 'safeguard' against such treatment i.e. whether it will partially prevent this treatment.

This line of argument does not only apply to homosexuality, but to all mental conditions. That is, if the extension of *mental disorder* is not dependent on the society in question, then it can be shown, for once and for all, whether any condition is a mental disorder. If a condition is a mental disorder, then it may be medically treated on the basis of being a mental disorder. (This applies to all societies.) On the other hand, if a condition is not a mental disorder, then that condition may not be medically treated on the basis of being a mental disorder i.e. the rhetoric of mental disorder may not be used to show that medical treatment of that condition is appropriate. The condition in question may not be treated on the basis of being a mental disorder in any society.

This argument is important because in past societies, homosexuality, masturbation, being a runaway slave and being a political dissident have all been medically treated on

the basis of being mental disorders. To most people in the developed world, medically treating these conditions (on the basis that they are mental disorders) seems to be an abuse of psychiatric power. (To be clear, this does not mean that people should not be medically treated if they want to curb their homosexual urges. Instead, it means that the medical treatment of these conditions on the basis that they are mental disorders – using the rhetoric of mental disorder – seems to be abusive.[15]) Put bluntly, it seems as if these conditions are not mental disorders, but are classified as such to justify medical (specifically psychiatric) treatment – it seems as if medicine is being improperly used as a façade for social control. For example, diagnosing political dissidents with sluggish schizophrenia seems to be a convenient (but deceptive) way of de-legitimising the views of political dissidents. This thesis does not endorse anti-psychiatry. I do not agree with Szasz's (1974) proposition that all psychiatric treatment is a guise for social control – I do not think that psychiatry is inherently abusive.[16] Instead, I think that psychiatry has the potential to be used for the purpose of social control, if conditions that are not mental disorders are medically treated on the basis of being mental disorders. For example, in 1999, the British Department of Health proposed a new mental disorder, dangerous severe personality disorder (DSPD) (Scally, 2016, 184). This was largely in response to the conviction of Michael Stone for the murder of a mother and child in 1998. Stone was considered to have a personality disorder, but psychiatrists considered his personality disorder to be untreatable, and so Stone could not be committed under the Mental Health Act 1983 (in England and Wales) (Scally, 2016, 185; Howells et. al., 2007, 325). Recognition of DSPD also legitimated the involuntary treatment of people who were deemed dangerous but had not yet committed a crime and did not have another mental disorder. Conceptualising DSPD as a mental disorder meant it was seen as a legitimate condition, which in turn meant that treatment options were researched. Once potential treatments were found, people with DSPD could be committed under mental health legislation. Recognising DSPD as a mental disorder also meant that those people who had not committed a crime could be involuntarily treated, which provided a degree of safety to the public. This is important

[15] Cases might arise in which the person seeking treatment for his or her homosexuality uses the rhetoric of mental disorder. In such a case, it is arguable that the medical treatment should be given, but that the treatment is not appropriate because homosexuality is not a mental disorder.

[16] Nor do I agree with Szasz (1974) that that unless it can be shown that mental disorders have a physical basis, then there is no basis for considering these conditions to be disorders.

because people with DSPD who have not committed a crime cannot be imprisoned. It is a fundamental principle of law that someone who has not committed a crime cannot be imprisoned, and "having a disposition or propensity to break the law is not a crime" (Szasz, 2003, 228-229).[17]

Many people saw DSPD as a political invention that used medicine as a guise to protect the public (Gunn, 2000; see also Szasz, 2003; Buchannan, 2001; Farnham, 2001; White, 2002). Based on this and other related problems, the diagnosis of DSPD no longer exists (Scally, 2016, 194). For another example, in the late 1990s and early 2000s, it was considered whether the diagnostic standards for schizophrenia should be extended to include a pre-psychotic stage, called Attenuated Psychosis Syndrome (Gosden, 1999). Such a diagnosis could easily be used for the purpose of social control, in a similar way to which sluggish schizophrenia was used for the purpose of social control.[18] In 2012, it was decided that Attenuated Psychosis Syndrome would not be included in the *DSM-5* (Yung et. al., 2012). This was not due to concerns about psychiatry being used for the purpose of social control, but because of limited and inconclusive evidence (Yung et. al., 2012, 1131).

To return to using the argument outlined above, if it can be shown that the extension of *mental disorder* is static between societies and if masturbation, being a runaway slave and being a political dissident do not fall within the extension thereof, then none of these conditions may be medically treated on the basis of being a mental disorder. This would apply in all societies i.e. even in those societies that deem these conditions to be mental disorders. In this way, the medical treatment of these conditions could be safeguarded against. Psychiatry could not be used for the purpose of social control.

While these four examples are all historical (excepting homosexuality, which is still considered to be a mental disorder in some societies) there might be other examples in which psychiatry is still being used as a guise for social control. In other words, there are other examples of mental conditions whose status as mental disorders is debated

[17] There are some exceptions to this rule. In New Zealand, some sexual or violent offenders might be given a sentence of preventive detention (section 87 Sentencing Act 2002) or a public protection order (Public Safety (Public Protection Orders) Act 2014). While these people have committed a crime, they have served their sentence, and so, in effect, are subject to ongoing imprisonment without having committed a crime. Another potential exception is that a person may be remanded in custody while awaiting trial.
[18] See section 3.4 of chapter two.

within a western framework. For example, the mainstream view is that Attention Deficit Hyperactivity Disorder (ADHD) is a mental disorder and ADHD is medically treated with, for example, methylphenidate (Ritalin).[19] However, a minority of people argue that ADHD is not a mental disorder but the consequence of expecting people to succeed in the structured environment of the classroom or office (see, for example, Timimi & Taylor, 2004; and Conrad & Potter, 2000). If ADHD is not a mental disorder, then the rhetoric of mental disorder cannot be used to justify the medical treatment of hyperactive people. It could also be argued that treating hyperactive people with Ritalin on the basis that ADHD is a mental disorder is an abuse of psychiatric power[20] – using psychiatry as a guise to justify the treatment of people who are not mentally disordered but socially deviant.[21] This thesis is agnostic on whether ADHD is a genuine mental disorder. Instead, the example is given to demonstrate that if the extension of *mental disorder* is not static, then ADHD might be a mental disorder in the developed world, but might not have been a mental disorder in a hunter-gatherer society. This might be beneficial as it would allow the extension of mental disorder to be tailored to the society in question. However, the downside is that many things that we, in the developed world, do not consider to be mental disorders, such as being a runaway slave, might be considered to be a mental disorder in other societies. Furthermore, in these other societies, those conditions may be medically treated on the basis of being mental disorders. In contrast, if the extension of mental disorder were fixed between societies, then there would be restrictions on what is a mental disorder. Whether a condition is a mental disorder would be static between societies, and in turn, whether that condition may be medically treated on the basis of being a mental disorder would also be static between societies. Put another way, if there were an extension of *mental disorder* that was static between societies, then it could be determined, for once and for all, whether the diagnosis and medical treatment of ADHD is an example of psychiatry being used as a guise for social control.

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[19] ADHD is included in both the fifth edition of the *Diagnostic and Statistical Manual* (*DSM-5*) and the tenth version of the International Statistical Classification of Diseases and Related Health Problems (*ICD-10*).
[20] See, for example, Norris and Lloyd in Mather, 2012, 19; and Conrad, 2006.
[21] 'Deviant' is a loaded term that usually has negative connotations. I do not call hyperactive people 'deviant' in the sense that the behaviour of hyperactive people is to be disvalued. Instead, I use 'deviant' to denote that those people whose behaviour or way of being are or has been disvalued by society in general. For example, hyperactive people are socially deviant in the sense that their hyperactivity is disvalued because it disrupts the classroom and work environment.

A further example is schizophrenia. The mainstream view is that schizophrenia is a mental disorder. However, there are those who debate whether schizophrenia is a mental disorder. As mentioned earlier, Szasz (1974) argues that unless it can be shown that mental disorders have a physical basis, there are no such things as mental disorders and that all psychiatric treatment is a guise for social control. Hence, Szasz would claim that schizophrenia is not a mental disorder, and the medical treatment of schizophrenia (on the basis that it is a mental disorder) is a misuse of psychiatry. In addition, Bentall (1993) and Boyle (1990) argue that schizophrenia is not a mental disorder because it does not meet the standards of scientific validity (Poland, 2007, 170). As argued with respect to ADHD, it would be beneficial if the extension of *mental disorder* were static, because it could show, for once and for all, whether schizophrenia is a mental disorder. It could also show, for once and for all, whether the medical treatment of these conditions is appropriate (on the basis that these conditions are mental disorders) or whether such treatment amounts to using psychiatry for the purpose of social control.

2. Thesis Argument

So far, it has been explained that a potential way of safeguarding (in part i.e. on the basis that they are not mental disorders) against the medical treatment of conditions such as homosexuality, masturbation, being a runaway slave and being a political dissident is to show that

1. Only mental disorders may be medically treated on the basis of being mental disorders, and
2. These conditions are not mental disorders in any society i.e. that the extension of mental disorder is static between societies and excludes these four conditions.

Regarding the second criterion, it needs to be shown that the extension of mental disorder is

2.1 Static between societies, and

2.2 Excludes homosexuality, masturbation, being a runaway slave and being a political dissident.

Chapter four shows that the first criterion can be fulfilled as there is a pragmatic link between mental disorder and medical treatment, and the rhetoric of mental disorder

only applies to mental disorders. In subsequent chapters, the thesis considers three ways in which the second criterion (i.e. both parts of the second criterion) might be fulfilled.[22] The first is basing the extension of *mental disorder* in ordinary language i.e. as it is currently used by health professionals and informed lay-people. The second is if *mental disorder* refers to or, more loosely, picks out a natural kind (either essentialist or family resemblance.) Additionally, if a component of *mental disorder*, such as *dysfunction,* picks out a natural kind, then this might mean that the extension of *mental disorder* is partly fixed between societies. Thirdly, the second criterion might be fulfilled if there are moral truths or Rawlsian primary goods concerning the extension of *mental disorder.* It is concluded that none of these approaches fulfil both components of the second criterion. Ordinary language, at least in very many places, excludes the four conditions (homosexuality etc.) but does not provide a static extension of *mental disorder. Mental disorder* does not pick out a natural kind. Moreover, even if *dysfunction* picks out a natural kind, it will not fulfil both components of the second criterion. If revisionist naturalism is accepted, the extension of *dysfunction* might be static, but might not exclude the four conditions. If conservative naturalism is accepted, the four conditions might be excluded, but it will not provide a static extension of *dysfunction.* Finally, Rawlsian primary goods might exclude the four conditions, but is highly unlikely to provide an extension of *mental disorder* that is static between societies*.*

In short, the thesis has not been able to verify the second criterion. The extension of *mental disorder* is not both fixed between societies and excludes the four conditions. This means that the medical treatment of homosexuality (and masturbation, being a runaway slave, being a political dissident or, indeed, any other condition) cannot be safeguarded against on the basis that they are not mental disorders. More generally, this approach cannot safeguard against psychiatry being used as a guise for social control.

3. Three notes on terminology

3.1 Concepts, terms and things in themselves

When referring to a concept (such as the concept *mental disorder*), the term is italicised. When not referring to the concept but the thing itself, the term is not italicised. When

[22] These approaches are the main ones that are available. While there may be other approaches, they are not considered in this thesis.

referring to the word (i.e. the term) MENTAL DISORDER, capital letters are used. Throughout this thesis, I refer to the 'extension of *mental disorder'.* By this, I mean the extension of the concept *mental disorder.* However, given that *mental disorder* is italicised, to say that I mean the extension of the concept is superfluous. At times, it is debatable whether a word should be italicised or capitalised. For example, in the claim 'in ordinary language, mental disorder is used to refer to …', one might have either the word (or phrase) MENTAL DISORDER in mind or the concept *mental disorder* in mind. I am predominantly interested in the concept of *mental disorder* as opposed to linguistic issues regarding the term MENTAL DISORDER. Hence, this thesis has a great many more italics than capitals.

3.2 Disorder, disease or illness?

Secondly, I acknowledge that there is an ongoing debate regarding whether mental disorders are members of the set of disorders (that is, whether the concept of *disorder* includes the concept of *mental disorder* as a sub-concept). I acknowledge but do not pay close attention to this debate. Currently, the idea that there are no such things as mental disorders has lost favour (Perring, 2010) and so I align myself with the mainstream view and presume that the concept *mental disorder* is a subset of the concept *disorder.* To refer to both physical and mental disorders, I use the term DISORDER. To refer solely to mental disorders, I use the term MENTAL DISORDERS.

There are multiple terms that could have been used instead of MENTAL DISORDER. For example, Boorse (1975) and Cooper (2007; 2002) use MENTAL DISEASE and Fulford (1989) uses MENTAL ILLNESS.[23] I consider these concepts to be roughly synonymous and have chosen to use MENTAL DISORDER. There are two reasons for this. Firstly, it is the concept used by Wakefield (1992), and Wakefield's account of *mental disorder* features prominently in this thesis and in the literature. Likewise, the *DSM* and the World Health Organisation's *International Classification of Diseases* (*ICD*) use MENTAL DISORDER. (The *ICD* uses DISEASE for physical conditions, but MENTAL DISORDER to refer to mental health problems.) Again, it makes sense to align my terminology with these tomes. Secondly, the concept *disease* is problematic insofar as in ordinary language, *disease* is usually taken to cover a rather narrow range of conditions such as malaria and cancer. In contrast, Boorse uses *disease* in a much broader way to include

[23] Clouser, Culver and Gert (1981) use MALADY to refer to both physical disorders and mental disorders.

broken bones, gunshot wounds and suffocation i.e. Boorse uses DISEASE to mean the absence of health (Boorse, 1987, 363-364). This broad conceptualisation of *disease* is equivalent to the concept *pathological condition* (Boorse, 1997, 551). In contrast, the way that DISORDER is used in everyday language is broader than the way DISEASE is ordinarily used. That is, MENTAL DISORDER is ordinarily used to refer to pathological conditions of the mind. Given that a large portion of this thesis focuses on ordinary language, MENTAL DISORDER is preferable to MENTAL DISEASE.

3.3 True extension v. Static Extension

So far, it has been explained that the thesis considers whether there is an extension of *mental disorder* that is static between societies. There are two ways in which the idea that 'there is an extension of *mental disorder* that applies in all societies' could be cashed out. Firstly, it could be said that there is a truth concerning the extension of *mental disorder.* Secondly, it could be asked whether the extension of *mental disorder* is static between societies. This thesis has opted to ask whether there is an extension of *mental disorder* that is static between societies (as opposed to whether there is a true extension thereof). The advantage of asking whether there is a static extension of *mental disorder* is that it clearly shows what I have in mind – whether the disorder-status of a mental condition can be determined for once and for all. In contrast, asking whether there is an extension of *mental disorder* that is true does not highlight that the thesis is interested in the fixedness of the extension of *mental disorder.* The advantage of asking whether there is a true extension of *mental disorder* is that it allows for some flexibility in the extension of *mental disorder.* This is beneficial because there are some examples in which whether a condition is a mental disorder seems to be genuinely dependent to the environment in question. For example, it is arguable that dyslexia might be a mental disorder in a literate society but not in a pre-literate society.[24] Asking whether there is

[24] Sickle cell anaemia is an example of which a physical condition may be a physical disorder in one environment but not another. Sickle cell anaemia is a genetic blood condition which causes fatigue, heart palpitations, shortness of breath, blood clots and the destruction of red blood cells. Sickle cell anaemia seems to be a paradigm example of a physical disorder. However, people with sickle cell anaemia have a thirty-three percent increase in immunity to a tropical form of malaria, *plasmodium falciparum* (Ruse, 1981, 17). It is arguable that sickle cell anaemia is a physical disorder in environments free of malaria, but is not a disorder in environments with malaria. See, for example, Engelhardt, 1996, 166 *C.f.* Boorse who claims that sickle cell anaemia is a disease (which I take to be analogous with 'disorder') that provides immunity to the more serious disease of malaria (Boorse, 1997, 89).

an extension of *mental disorder* that is static between societies does not allow for this flexibility.

Despite this, this thesis does not ask whether there is a true extension of *mental disorder*. This is because, as already explained, this might mean that homosexuality is considered to be a mental disorder in homophobic societies, being a political dissident is considered to be a mental disorder in dictatorships, and so on.[25] That is, allowing for flexibility is dangerous insofar as psychiatry could be used as a guise for social control. This is not to say that a true extension of *mental disorder* means that anything goes i.e. that a true extension of *mental disorder* could not put any limits on its scope, or that whether a condition is a mental disorder is entirely relative to the culture in question. However, this thesis focuses on ways in which it might be shown that conditions such as homosexuality are not mental disorders in any society. Hence, while the thesis recognises that a degree of flexibility in the extension of *mental disorder* would be beneficial, the thesis still asks whether there is an extension of *mental disorder* that is static between societies. My hope is that this thesis will ask whether there is a fixed extension of *mental disorder*, and a later piece of work will consider whether the fixed extension of mental *disorder* can be tempered to allow that certain conditions (e.g. dyslexia might be mental disorders in some societies but not others), while also ensuring that it remains that conditions such as homosexuality are not mental disorders in any society.

4. Thesis Structure

This main part of the thesis is comprised of two parts. Part one consists of chapters two, three and four. This part focuses on the first of the two criteria outlined above - only mental disorders may be medically treated on the basis of being mental disorders. Chapter two provides a historical basis to the link between mental disorder and medical treatment, and also explains my motivation for wanting to safeguard against the medical treatment of conditions such as homosexuality. Chapter three considers ways in

[25] Equally, every disorder is advantageous in a Nazi concentration camp in which medical research is being carried out to cure that disorder (Boorse, 1997, 89). That is, a person with the disorder being researched will not be gassed or otherwise killed, and so will live for longer than a person without that disorder.
In other words, I do not endorse the ideas health equals adaptation to the environment and that disorder equals maladaptation to the environment.

which the medical treatment of conditions such as homosexuality might be safeguarded against, and concludes that a potentially promising way of doing so is to claim that a) only mental disorders may be medically treated on the basis of being disorders, and b) that homosexuality and so on are not mental disorders in any society. Chapter four shows that there is a pragmatic link between mental disorder and medical treatment, and so the first criterion is fulfilled.

Part two, which is made up of chapters five through eight, concentrates on the second of the two criteria i.e. conditions such as homosexuality are not mental disorders in any society. (This includes both parts of the second criterion i.e. whether there is an extension of *mental disorder* that is static between societies and excludes homosexuality, masturbation, being a runaway slave and being a political dissident.) Chapter five considers whether basing the meaning of *mental disorder* on the way it is used in ordinary language can meet both parts of the second criterion. Chapters six and seven consider whether natural kinds can meet these objectives. Chapter eight considers whether the value-status of a mental state can be fixed using moral truths or primary goods, and in turn, whether the second criterion can be fulfilled.

The conclusion ties together the material discussed throughout the thesis, and concludes that the medical treatment of conditions such as homosexuality cannot be safeguarded against by showing that they are not mental disorders in any society. The coda offers suggestions for further consideration.

Part One

Part one focuses on the first criterion, namely, showing that only mental disorders may be medically treated on the basis of being mental disorders.

Chapter Two: Four Historical Case Studies

The second chapter explains, in more detail, that in some societies – both past and present –homosexuality is considered to be a mental disorder. In turn, medical treatment was used in an attempt to 'cure' a person of homosexuality. It also explains that, in some societies of the past, masturbation, being a runaway slave and being a political dissident have been both considered to be mental disorders and medically treated. There are two main points to be taken from the four historical case studies. The first is that the extension of *mental disorder* changes depending on the society in

question. Secondly, these conditions were medically treated on the basis of being mental disorders. (The link between mental disorder and medical treatment is considered in detail in chapter four.) Chapter two also considers conditions whose status as a mental disorder is debated within the developed world, such as ADHD.

Chapter Three: Ways of showing that a condition should not or may not be medically treated

Chapter three considers three ways in which it could be argued that homosexuality, along with masturbation, being a runaway slave and being a political dissident, should not or may not be medically treated. The first way is to show that these conditions should not be medically treated, if the treatment does not balance the standard bioethical criteria, namely, benefit to the patient, harm minimisation and consent (where required). (This section also discusses Fulford's (2004a) values-based medicine.) The second way is to argue that only disorders may (*c.f.* should) be medically treated. The third method is to show that only mental disorders may be medically treated on the basis of being mental disorders. On this approach, non-disorders may be medically treated, but the rhetoric of disorder cannot be used to justify the medical treatment thereof. This thesis utilises the third approach.

Chapter Four: The link between mental disorder and medical treatment

Chapter four begins by defining medical treatment as those products and services, both effective and ineffective, that are provided by health professionals in their capacity as health professionals. It then considers the link between a condition being a mental disorder and medical treatment. It shows that while there is no exclusive prescriptive link between mental disorder and medical treatment, there is a pragmatic link between the two insofar as it is appropriate to medically treat mental disorders i.e. that the medical treatment of mental disorders makes sense. This is because both mental disorders and medical treatment fall within the Asclepian frame.

Part Two

Part two focuses on the second of the two criteria, namely, whether it can be shown that conditions such as homosexuality are not mental disorders in any society.

Chapter Five: Conceptual Analysis and Ordinary Language Philosophy

This chapter begins the consideration of the meaning of *mental disorder* and considers the way *mental disorder* is used in ordinary language, specifically the way it is used by

health professionals in clinical settings and informed lay-people in serious situations. It shows that this sense of *mental disorder* has three necessary and sufficient components, namely, that the condition is mental (as opposed to physical), caused by a dysfunction and disvalued. The previous four chapters have presumed that homosexuality is not a mental disorder. From this chapter onwards, it is asked whether it is the case that homosexuality cannot be a mental disorder in any society.

Chapter five shows that basing the extension of *mental disorder* in ordinary language means that homosexuality and so on are not mental disorders, at least in the developed world. However, ordinary language does not fix the extension of *mental disorder* between societies. Hence basing the extension of *mental disorder* in ordinary language will not fulfil the first component of the second criterion, and hence the second criterion cannot be fulfilled i.e. it will not show that conditions such as homosexuality are not mental disorders in any society.

Chapter Six: Do *mental disorder* or *dysfunction* pick out natural kinds?

Chapter six shows that as disvalue is a necessary component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people, this sense of *mental disorder* cannot pick out a natural kind (either essentialist or family resemblance). Despite this, chapter six shows that *dysfunction* (being a component of *mental disorder)* might pick out a natural kind. If so, then it is arguable that the extension of *dysfunction* will not change between societies*.* In turn, part of the extension of *mental disorder* will not change between societies. Hence, the first component of the second criterion might be fulfilled. Rather than showing that *dysfunction* picks out a natural kind, this chapter (along with chapter seven) considers the implications of *dysfunction* being a natural kind, specifically whether it will fix the extension of *dysfunction.*

Chapter Seven: Natural Kinds continued – Conservative and Revisionist Naturalism

The chapter first considers Murphy and Woolfolk's (2000; 2000a) claim that Wakefield is a conservative naturalist i.e. that Wakefield thinks natural kinds are constrained by ordinary language. I argue that while Wakefield is a black box essentialist, it is unclear whether he is a conservative naturalist. This chapter then continues the discussion of whether criterion two can be fulfilled i.e. whether the natural kind dysfunction (presuming it exists) can show that conditions such as homosexuality are not mental disorders in any society. It is shown that conservative naturalism means that

homosexuality cannot fall within the natural kind dysfunction (presuming it exists) at least in the developed world, but does not provide a static extension of *dysfunction* (and in turn, *mental disorder*). Revisionist naturalism does provide a static extension of *dysfunction,* but cannot ensure that homosexuality is not caused by a dysfunction. In short, even if *dysfunction* picks out a natural kind, neither revisionist naturalism nor conservative naturalism can fulfil both components of criterion two.

Chapter Eight: Are the values concerning *mental disorders* fixed?

If the value-status of mental states were fixed, the extension of *mental disorder* would be fixed i.e. static between societies. Chapter eight argues that while moral truths could be used to show that the value-status of mental states are fixed, Mackie's (1977) argument from queerness means that this is unlikely to be successful. Instead, chapter eight argues that Graham's (2013) basic psychological capacities are Rawlsian primary goods concerning mental states. To include all conceptions of the good life, the basic psychological capacities need to be expansive. However, this expansiveness means that the basic psychological capacities are unlikely to fix the extension of *mental disorder* (criterion 2.1). An additional problem is Graham's claim that an inability to grasp morality might be indicative of a mental disorder.

Chapter Nine: Conclusion

The aim of the concluding chapter is to tie up any loose ends and to outline my position. The thesis concludes that none of the approaches considered (ordinary language, conservative naturalism and revisionist naturalism regarding dysfunction, and primary goods) can ensure that conditions such as homosexuality are not mental disorders in any society. That is, while the first criterion (only mental disorders may be medically treated on the basis of being disorders) is true, the second criterion is not. That is, both components of the second criterion cannot be simultaneously fulfilled. It is either the case that the extension of *mental disorder* is static between societies or that conditions such as homosexuality are excluded from the extension thereof. We cannot both have our cake and eat it. Hence, it cannot be said that those who consider conditions such as homosexuality to be mental disorders, and medically treat them on this basis, are wrong. Two methods that might be more fruitful are considered. Firstly, it is considered whether the medical treatment of conditions such as homosexuality could be safeguarded against using the established norms in medical ethics, such as the need (in

most cases) for informed consent and that the treatment does not unduly harm the patient. Secondly, it is briefly considered whether Fulford's (2004a) values-based medicine (VBM) might safeguard against the medical treatment of these conditions. (Both these approaches are outlined in section two of chapter three.)

PART ONE – THE LINK BETWEEN MENTAL DISORDERS AND MEDICAL TREATMENT

Chapter Two – Historical Case Studies

1. Introduction

This thesis consists of an analysis of a philosophical and ethical issue in the philosophy of psychiatry, specifically whether it can be shown that a condition is or is not a mental disorder in all societies, and in turn whether it can be shown that that condition may be medically treated on the basis of being a mental disorder. The intension (meaning) and extension (scope) of *mental disorder* has been the subject of intense debate since the 1970s. A major reason for this is that homosexuality was removed from the American Psychiatric Association's second edition of the *Diagnostic and Statistical Manual (*i.e. the *DSM-II)* in 1974 (Rubinstein, 1995; Spitzer, 1981). In effect, this meant that gay people were cured of a mental disorder, not by eradicating homosexuality, but by a classificatory change.

It is not only homosexuality that has changed mental disorder status. This chapter explains three further conditions that were once considered to be mental disorders, but are no longer considered to be mental disorders in the developed world. These conditions[26] are masturbation, drapetomania (i.e. being a runaway slave) and sluggish schizophrenia (i.e. being a political dissident). The extension of *mental disorder* matters because, as will be established in chapter four, the medical treatment of mental disorders is appropriate. If homosexuality (or masturbation, drapetomania or sluggish schizophrenia) is a mental disorder, then the medical treatment of that condition is appropriate. If homosexuality or any other condition is not a mental disorder then the medical treatment of that condition is not appropriate, at least, on the basis that the condition in question is a mental disorder.

To determine whether homosexuality, masturbation, drapetomania and sluggish schizophrenia may be medically treated on the basis of being mental disorders, it needs to be determined whether these conditions are mental disorders. In order to determine

[26] 'Condition' is used as a neutral term to pick our states that might potentially be mental disorders

whether these conditions are mental disorders, the meaning of *mental disorder* requires consideration. Section one of this chapter gives a brief rundown of the ways in which *mental disorder* can be conceptualised. This is not an exhaustive analysis of the conceptualisation of *mental disorder* but is, instead, intended to facilitate the discussion in the remainder of this chapter.

The second section of this chapter discusses the four case studies – homosexuality, masturbation, drapetomania and sluggish schizophrenia. There are two main reasons for discussing these four case studies. Firstly, they introduce the idea that a condition can be considered to be a mental disorder in one society, but that same condition is not considered to be a mental disorder in some other society. Secondly, the case studies introduce the link between mental disorder and medical treatment – considering a condition to be a mental disorder means that the medical treatment of that condition is appropriate. In contrast, if a condition is not a mental disorder, then medical treatment of that condition is not appropriate, at least on the basis that the condition is a mental disorder. The link is only introduced here, but is discussed in more detail in chapter four.

As the extension of *mental disorder* can change between societies, whether the medical treatment of that condition is appropriate might also change between societies. It might be appropriate, for example, to medically treat homosexuality in some societies but not others. Consequently, although most people in the developed world find the medical treatment of homosexuality abhorrent, the medical treatment of homosexuality cannot be safeguarded against simply by showing that homosexuality is not a mental disorder. Instead, it needs to be shown that homosexuality is not a mental disorder in any society. The same applies to the other three case studies, and, as will be shown in the final section of this chapter, any other condition for which its status as a mental disorder is debatable.

In short, the aim of this chapter is twofold. The first is to provide a historical basis to the link between mental disorder and medical treatment. The second is to explain my motivation for wanting to safeguard against the medical treatment of conditions such as homosexuality.

2. The meaning of *mental disorder*

It cannot be determined whether a condition is a mental disorder (and whether it may be medically treated on the basis of being a mental disorder) without knowing what *mental disorder* means. The meaning of *mental disorder* is discussed at length throughout this thesis. This section only provides a starting point i.e. a rough and ready account of the meaning of *mental disorder.* Much of what is said in this section is considered in more detail in chapter five. One way of determining the meaning of *mental disorder* is to consider the way it is ordinarily used by health professionals in clinical settings and informed lay-people in serious situations.[27] This sense of *mental disorder* has three necessary and sufficient elements:

1. Mental disorders must be mental as opposed to physical.
2. Mental disorders must be disvalued as opposed to valued or value-neutral.
3. Mental disorders must involve something going wrong (with the mind).[28]

Regarding the first condition, mental disorders are conditions of the mind as opposed to physical conditions. This applies to both symptoms and causes. The causes of mental conditions are mental i.e. in the brain or mind. The symptoms of mental disorders are also largely mental (c.f. for example, psychosomatic disorders such as conversion disorder). For example, broken arms are not mental disorders because a broken arm has a physical cause, and the symptoms are largely physical (perhaps excluding pain which is arguably a mental phenomenon). Secondly, valued or value-neutral conditions are not mental disorders. For example, being happy or intelligent are not mental disorders.[29] Likewise, while there is (or was) a debate about whether homosexuality is a mental disorder, there is no debate about whether heterosexuality is a mental disorder.

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[27] There are other ways in which *mental disorder* can be conceptualised. For example, *mental disorder* can be conceptualised as whatever health professionals treat or an unexpected distress or disability (Wakefield, 1992, 377-381).

[28] It could be argued that even if these three conditions are necessary, they are not sufficient. For example, forgetting where I put my keys is both mental and disvalued. It is also arguably an example of something going wrong with the mind. This would mean, according to my criteria, forgetting where I put my keys would be a mental disorder, even though we would not ordinarily call this a mental disorder. However, it is doubtful whether forgetting where I have put my keys is indicative of something going wrong with my mind, as it seems to be part of ordinary (non-dysfunctional) forgetfulness. Hence, I maintain that the three elements are sufficient (as well as necessary) for a condition to be a mental disorder.

[29] *C.f.* Bentall, 1992 and Harris *et. al.,* 1993.

This is because heterosexuality is not disvalued.[30] This makes me a normativist regarding *mental disorder.* As Wakefield says, an evaluative component is an "important truth" regarding *disorders* (Wakefield, 1992, 376). In contrast, naturalists regarding *mental disorder* claim that it is a value-free concept. For example, Christopher Boorse (1976; 1975) argues that *disease* (which includes mental diseases) is a value-free concept, namely a statistically abnormal mental dysfunction. [31] The problem with value-free accounts of *mental disorder* is that they do not reflect the way *mental disorder* is ordinarily used by health professionals and informed lay-people. Strong normativists claim that disvalue is both necessary and sufficient for a condition to be a *mental disorder* i.e. that *mental disorder* is a purely evaluative concept. For example, Sedgwick, a strong normativist, says that, "all sickness is essentially deviancy [from] some alternative state of affairs which is considered more desirable" (Sedgwick, 1982, 32).[32] A disadvantage of strong normativism is that it fails to recognise that there are disvalued mental conditions that we do not ordinarily consider to be mental disorders. For example, health professionals and informed lay-people do not ordinarily call the grief experienced after the death of a loved one a mental disorder. Another problem with strong normativism is that it makes *mental disorder* "a completely value and culture-relative notion with no scientific content whatsoever" (Wakefield, 1992, 376).

Weak normativism can account for both these problems (of naturalism and strong normativism). Weak normativists claim that disvalue is necessary but not sufficient for a condition to be a mental disorder. For example, a weak normativist will argue that in addition to being disvalued, all mental disorders must involve something going wrong with the mind.[33] For example, if post-bereavement grief does not involve anything going wrong with the mind, then post-bereavement grief is not a mental disorder. As will be shown in the remainder of this chapter, whether 'something has gone wrong with the

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[30] That is, I do not know of any society in which heterosexuality is disvalued. However, if heterosexuality turns out to be disvalued by some society and involve something going wrong with the mind, then it would be a mental disorder in that society. See also Bentall (1992) on the classification of happiness (being a mental state that is not disvalued) as a mental disorder.

[31] Mental disease can be taken to be roughly analogous to mental disorder. See section x of chapter one. While Boorse thinks *disease* is a value-free concept, he argues that this can be built on to produce the hybrid (both descriptive and evaluative) concept *disease-plus* (Boorse, 2014; 1997, 11-13).

[32] See for example Sedgwick on the snapping of a septuagenarian's femur and the snapping of an autumn leaf from its twig (Sedgwick, 1982, 30) and Wakefield's response (Wakefield, 1992, 376).
As per section two of chapter one, Sedgwick's *sickness* can be taken to be roughly analogous to *disorder.*

[33] This incorporates the first element i.e. that all mental disorders must be mental. For the sake of brevity, I say that all mental disorders must be disvalued and involve something going wrong with the mind.

mind' is a value-free claim is controversial. If it is value-free, then the meaning of *mental disorder* would be partly descriptive and partly evaluative. Hence, this conceptualisation of *mental disorder* is very similar to that of Jerome Wakefield. Wakefield (1992) claims that all mental disorders must be harmful mental evolutionary dysfunctions.[34] Wakefield's position is weakly normative as he claims that harm is value-laden, while mental dysfunction is value-free.

In short, *mental disorder*, as ordinarily used by health professionals and informed lay-people, means those mental conditions that are disvalued and something going wrong with the mind. This weakly normative account of *mental disorder* accounts for the important truths that a) disvalue is a necessary component of the way *mental disorder* is used in ordinary language, and b) not all disvalued conditions are ordinarily called mental disorders. Moreover, weak normativism allows for factual, scientific content to be relevant to whether a condition is a mental disorder. This brief rundown of the meaning of *mental disorder* is not comprehensive, but is only intended to facilitate the discussion in the remainder of this chapter. That is, providing a tentative or working definition of *mental disorder* enables discussion of whether the four cases studies (homosexuality, drapetomania, masturbation and sluggish schizophrenia) were considered to be mental disorders, and whether these conditions were medically treated on the basis of being mental disorders.

3. Historical case studies

3.1 Homosexuality

Homosexuality has been considered acceptable in some times and cultures, and unacceptable in other times and cultures. For example, homosexuality was often acceptable in ancient Greece and ancient Rome (Sullivan, 2004, 4).[35] Societies that disvalue homosexuality consider it to be immoral, illegal, sinful, a mental disorder or some combinations of these. In nineteenth century Europe, homosexuality began to be

[34] More precisely, for a condition to be a mental disorder, the harm needs to be caused by a mental dysfunction (Pickering, 1996, 90).

[35] Nussbaum argues that this did not include penetrative sex (Nussbaum, 1999, 268, 307-308, 335). Williams claims that ancient Rome did not have a term that translates precisely to homosexuality (the same applies for heterosexuality) (Williams, 1999, 304). This raises the interesting question of whether ancient Roman's had the concept *homosexuality* or something different.

thought of, by some[36], as a mental disorder, specifically a congenital and/or hereditary condition (Beachy, 2010). In the late nineteenth century, Freud argued that homosexuality (or 'inversion' as he called it) was sometimes caused by incomplete psychosexual development i.e. the failure to move on from childhood bisexuality (Beachy, 2010).

There are some societies, groups or organisations that still consider homosexuality to be a mental disorder.[37] For example, many people in China[38] and Serbia[39] consider homosexuality to be a mental disorder. Moreover, some fundamentalist Christians and orthodox Jews classify homosexuality as a mental disorder (see Halper & Price, in Earp *et al.*, 2014) and NARTH along with the Indonesian Psychiatric Association still considers homosexuality to be a mental disorder (Yosephine, 2016).[40] The previous section explained that for a condition to fall within the extension of *mental disorder* (as ordinarily used by health professionals in clinical settings and informed lay-people in serious situations), it must involve something going wrong with the mind and be disvalued. There is very little information regarding the reasons these societies classify homosexuality as a mental disorder. This thesis takes it for granted that the intension of *mental disorder* (*c.f.* the extension thereof) has not changed over time and culture. That is, the thesis presumes that societies that consider homosexuality to be a mental disorder (for example, nineteenth century Europe, modern-day China, Serbia, Indonesia and in societies of fundamentalist Christians and orthodox Jews) have the same concept of *mental disorder* as currently used in the developed world – a disvalued condition in which something has gone wrong with the mind. This means that for homosexuality to be a mental disorder in these societies, homosexuality must be both disvalued and considered to involve to something going wrong in the mind.

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[36] For example, Karl Heinrich Ulrich, Jean Martin Charcot and Havelock Ellis (Beachy, 2010).
[37] It is debateable whether an organisation like the Indonesian Psychiatric Association and NARTH are societies. Rather than saying 'societies, groups or organisations' each time I need to refer to these bodies, I use 'society' as a shorthand.
[38] Human Rights Watch, 2017. See also BBC, 2017.
[39] In 2008, 70% of people living in Serbia considered homosexuality to be a mental disorder (Blagojević, 2011).
[40] Given that the majority of Indonesians are Muslim, it is plausible that there is a connection between religion and the Indonesian Psychiatric Association's classification of homosexuality as a mental disorder.

In 1952, the American Psychiatric Association (APA) published the first edition of the Diagnostic and Statistical Manual of Mental Disorders (the *DSM*). The *DSM* included homosexuality as a mental disorder as a type of paraphilia (i.e. disordered sexual behaviour) (APA, 1952). However, in the western world by the 1960s and 1970s, the debate about whether homosexuality was a mental disorder intensified. Gay activists (including gay psychiatrists) began lobbying for the removal of homosexuality from the *DSM.* They picketed outside meetings of the APA and sometimes even disrupted them. In 1974, a referendum was held in which 58% of APA members voted in favour of removing homosexuality from the *DSM.* As Gary Greenberg said, "this may have been the first time in history that a mental disorder was eradicated at the ballot box" (Greenberg, 2010, 236). Greenberg did not mean that there were no longer gay people as a result of the referendum, but that homosexuality was no longer classified as a mental disorder. (Although homosexuality was removed from the *DSM-II,* the *DSM-III* replaced homosexuality with ego-dystonic sexuality disorder (Rubinstein, 1995; Spitzer, 1981). Ego-dystonic sexuality disorder occurs in cases in which a person has a sexual orientation at odds with one's idealised self-image that causes anxiety. This was removed in the revised version of the *DSM-III* i.e. the *DSM-III-TR*.[41])

Presuming that all mental disorders are disvalued conditions in which something has gone wrong with the mind, there are two possible reasons why homosexuality was removed from the *DSM.* [42] The first is that people judged that homosexuality was not to be disvalued i.e. it was realised that the only disvaluable or harmful outcome of being gay occurred due to social oppression. As mentioned above, this might be independent of scientific evidence, but it might be influenced if it were found that homosexuality does not involve something going wrong with the mind. In addition, while homosexuality is not disvalued by most people in the developed world, it might be that homosexuality stopped being disvalued when it was removed from the *DSM.* The second potential reason why homosexuality was removed from the *DSM* is that scientific evidence had changed such that homosexuality was no longer considered to involve

[41] Moser argues that it is possible that it could be included in the DSM-5's category of paraphilia if a gay person were considered to be hypersexual on the basis that they could not control their homosexual urges (Moser, 2011, 228).

[42] It might have been decided that homosexuality is not a mental but a physical condition. This is highly unlikely and will not be discussed further.

something going wrong with the mind. This might have occurred independently of values, but as mentioned above, it might have been that the scientific evidence (that homosexuality is not a mental disorder) is influenced by values.

The dominant view is that homosexuality was removed from the *DSM* because it was no longer disvalued. As Bayer famously says, people voted to remove homosexuality from the *DSM* not based on new scientific knowledge, but due to "the ideological temper of the times" (Bayer, 1981, 4). Equally, Spitzer argued that the intractability of the debate over whether homosexuality is a mental disorder was concerned with values, not facts (Spitzer, 1981, 210). Both Bayer and Spitzer were aware of both factual and value judgments regarding disorder attributions, but concluded that evaluative concerns played the main role (Greenberg, 1997, 259).[43] One minority view, as espoused by Kitzinger, is that homosexuality was considered to be a mental disorder in the past because people "were blinded by religious prejudice and trapped by the social conventions of their time: their research lacked present-day sophistication and objectivity" (Kitzinger, 1987, 8). Kitzinger goes on to say that nowadays "in our sexually liberated age, with the benefit of scientific rigour and clear vision, objective up-to date research demonstrates that lesbians and gay men are just as normal, just as healthy … as are heterosexual people" (Kitzinger, 1987, 8). That is, Kitzinger thinks that homosexuality does not involve something going wrong with the mind and that homosexuality is disvalued, but that the two components are independent of each other.

In short, conceptualising *mental disorder* as a 'disvalued condition in which something has gone wrong with the mind' means homosexuality might be a mental disorder in one society but not another. Whether it is a mental disorder in a certain society depends on both its value-status and science (i.e. whether it is considered to be caused by something going wrong with the mind). The science and value-status might not be independent, which makes it difficult to make a definitive claim concerning the reason why homosexuality was removed from the *DSM.*

[43] This view has been extended by some such that homosexuality was removed from the DSM because it was no longer disvalued which led to the claim that homosexuality does not involve something going wrong with the mind. See, for example, Murphy and Woolfolk, 2000a, 288-289 on this debate applied to the issue of whether the female orgasm (or lack thereof) is a disorder *c.f.* Wakefield, 2000a, 265-266.

In those societies in which homosexuality is considered to be a mental disorder, homosexuality is medically treated.[44] For example, during the nineteenth century, medical treatment of homosexuality included transplanting the testicles of a straight man to a gay man (King & Bartlett, 1999, 107). During the twentieth century, some gay people took part in Freudian psychoanalysis. Others were prescribed oestrogen to reduce their libido and/or given Electro-Convulsive Therapy (ECT) (Smith, Bartlett & King, 2004). Aversion therapy and covert sensitisation were also used. Aversion therapy consisted of pairing homoerotic stimuli with electric shocks or nausea-inducing drugs (King & Bartlett, 1999; Haldeman, 1991, 1994, 2002). Regarding covert sensitisation, Malesky and George (1973), for example asked gay men to imagine that

> You are at the beach with a special person … You lie down behind a sand dune and start to embrace and undress each other. You can see his penis hard and stiff. He starts rubbing it back and forth. But as you get closer you notice a strange odor and you see small white worms like lice, crawling in the hair around his penis! You're touching them with your mouth! It's disgusting and it's making you sick . . . they're crawling into your mouth . . . big chunks of vomit come into your mouth (Malesky & George in King & Bartlett, 1999, 109-110).

While the medical treatment of homosexuality occurred to both gay men and gay women, the treatment of gay women is not well documented. King and Bartlett parallel this with the facts that female homosexuality was often not criminalised and women were rarely arrested for being gay (King & Bartlett, 1999, 109).[45]

There is very little written about the medical treatment that current homophobic societies give to gay people. However, the Human Rights Watch group found that gay Chinese people are medicated, given covert sensitisation therapy (injected with nausea-inducing medication while watching gay pornography) and given ECT. Regarding ECT, Li Zhen explained that

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[44] Chapter four will argue that medical treatment is appropriate for mental disorders. Hence, in societies in which homosexuality is consider to be a mental disorder, the medical treatment of homosexuality is appropriate. The exact nature of the link between mental disorder and medical treatment is not at issue here.

[45] Likewise, when homosexual acts were criminalised in Victorian England, Queen Victoria refused to believe that lesbian acts were physically possible and so any reference to lesbianism was removed from the Sexual Offences Act before it was given the Royal Assent (Martin, 1994, 428). *C.f.* Hoffman who considers whether this may be a myth insofar as Queen Victoria did not have anything to do with Acts of Parliament (Hoffman, 2013, 2-3).

> The doctor asked me to lie down and relax. He started to play very gentle and slow music, at a very low volume. He asked me to think about my intimate moments with my boyfriend. He asked me to relax and start imagining having sex with my boyfriend… then all of a sudden, I felt a very short but strong pain on my left forearm, as if my arm was stabbed by something very sharp. I jumped off the couch I was lying on and started yelling at the doctor and asked him what the hell that was. He told me it was electroshock treatment… I don't feel the pain anymore. But I remembered I was so scared and did not know what could have happened to me. I don't want it to continue doing that. I asked him to stop the session. The psychiatrist said that would be it for that session, but I would need to be ready for more sessions of electroshock for this to work (Human Rights Watch, 2017).

As will be discussed in chapter three, one way of showing that homosexuality should not be medically treated is to show that the medical treatment is not consensual, does not benefit the patient, does not minimise harm or some combination of these. Only some of the medical treatment of homosexuality was compelled by the state. Some people agreed to be treated. Although consent was given, the freedom of this consent is debatable.[46] Some people, including Alan Turing, consented to conversion therapy to avoid going to prison (Hodges, 2012, 471-476). It is likely that others consented to conversion therapy on the basis that society was homophobic, and they would do better as a straight person. Presumably, some gay people would have themselves been homophobic and considered themselves to be disordered and so consented to treatment on this basis. Others would have consented to therapy to please their family members. For example, Xu Zhen, a twenty-one year old, Chinese lesbian consented to conversion therapy in 2014, after being pressured by her parents. When Xu Zhen told her parents she was gay, she said,

> My mom started… screaming about unfortunate things happening to our family, how she could ever survive it… My dad kneeled down in front of me, crying, begging me to go [to the conversion therapy]. My dad said he did not know how to continue living in this world and facing other family members if people found out I was gay. He was begging me to go so that he could live… I mean, at that point, what else could I do? I didn't really have any other options. (Human Rights Watch, 2017).

There is little evidence that conversion therapy was effective (Haldemann, 1991) or is effective (Earp *et. al.,* 2014, 7; Human Rights Watch, 2017). While psychoanalysis was

[46] Persuading people to consent to medical treatment for a mental disorder still occurs (Sørgaard, 2007).

often reported as being effective, the studies that made such claims were often "haphazard and biased" (King & Bartlett, 1999, 109). Moreover, these therapies were often harmful. People who experienced conversion therapy sometimes attempted or committed suicide or became depressed (sometimes psychotically so). Others lost the ability to orgasm during sex, heterosexual or homosexual. Sometimes death occurred via dehydration caused by the nausea-inducing drugs and others died from inhaling vomit (Haldeman, 1991; 1994; 2002; King and Bartlett, 1999, 110; Hicks in Earp *et. al.,* 2014, 7). While harm clearly occurred, it might well have been thought that the benefit produced by the treatment outweighed the harm, at least from an aggregate perspective i.e. when not looking at the individual cases. Moreover, if it was believed that being gay was a mental disorder, then health professionals might be obliged to take steps to cure a person of their ailment, at least insofar as the benefit of the treatment outweighed the harm caused by being gay (see Hare, 1962, 11 and section 3.3 of this chapter).

Since the removal of homosexuality from the *DSM*, there has been a sea-change in the literature regarding the medical treatment of homosexuality. When homosexuality was included within the *DSM* (i.e. when it was considered to be a mental disorder), the literature almost exclusively focused on how to make gay people straight. Nowadays, the literature is much more likely to consider affirmative therapeutic approaches which help a gay person accept his or her sexuality (Zucker, 2003, 399; Davison, 2001, 696). That homosexuality is not considered to be a mental disorder in the developed world, is a way of signaling that the medical treatment of homosexuality is dubious or fishy i.e. that the medical treatment of homosexuality might be inappropriate.[47]

The purpose of this section is to introduce two ideas. Firstly, conceptualising *mental disorder* as a 'disvalued condition in which something has gone wrong with the mind' means homosexuality might be a mental disorder in one society but not another. Secondly, in those societies in which homosexuality is considered to be a mental disorder, the medical treatment is considered appropriate. Equally, in societies that do

[47] See also Nicolosi who argues that removing homosexuality from the DSM had the undesirable (according to him) consequence of discouraging research and treatment of homosexuality (Nicolosi, 2012, 13).

not consider homosexuality to be a mental disorder (including the developed world), the medical treatment of homosexuality might be inappropriate.

3.2 Drapetomania (and dysaesthesia Aethiopica)

In 1851 (prior to the civil war in the United States of America), Samuel Cartwright claimed to have discovered the mental disorders of drapetomania and dysaesthesia Aethiopica. Drapetomania was symptomised by black slaves running away from their masters and/or by slaves who saw themselves as being on an equal level with his (or her) master. The main symptom of dysaesthesia Aethiopica was being an indolent slave. Cartwright says

> When left to himself, the negro indulges in his natural disposition to idleness and sloth, and does not take exercise enough to expand his lungs and to vitalize his blood, but dozes out a miserable existence in the midst of filth and uncleanliness, being too indolent and having too little energy of mind to provide for himself proper food and comfortable lodging and clothing… When aroused from his sloth by the stimulus of hunger, he takes anything he can lay his hands on, and tramples on the rights, as well as on the property of others, with perfect indifference as to consequences. When driven to labor by the compulsive power of the white man, he performs the task assigned him in a headlong, careless manner, treading down with his feet, or cutting with his hoe the plants he is put to cultivate—breaking the tools he works with, and spoiling everything he touches that can be injured by careless handling (Cartwright, 1851/2004, 36).

Cartwright argued that God intended black people to be "submissive knee-benders" (Cartwright, 1851/2004, 35). If a white man treats black people as his equals then he "abuses the power given to him by God" (Cartwright 1851/2004, 35). He says that physicians in the northern states of the USA

> ignorantly attribute the symptoms to the debasing influence of slavery on the mind, without considering that those who have never been in slavery, or their fathers before them, are the most afflicted, and the latest from the slave-holding South, the least. The disease is the natural offspring of negro liberty—the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks (Cartwright, 1851/2004, 36).

Cartwright said if a slave ran away or became sulky for no good reason, then the slave had fallen "into the negro consumption" i.e. they had the mental disorder of drapetomania or dysaesthesia Aethiopica (Cartwright, 1851/2004, 35). Note that,

regarding reasons, Cartwright thought that so long as the master had provided for the slave's physical wants, then this was not sufficient justification for a slave to run away or sulk – such a slave might be diagnosed with drapetomania or dysaesthesia Aethiopica.

As shown in section one of this chapter, a condition is a mental disorder if it is both disvalued and involves something going wrong with the mind. Let us presume that this intension of *mental disorder* also applied during Cartwright's time. This means that Cartwright and his cronies must have disvalued drapetomania and thought it involved something going wrong with the mind.[48] Drapetomania is no longer considered to be a mental disorder. As discussed in the section on homosexuality, there are two potential reasons for this. The first is that drapetomania is no longer a mental disorder because being a runaway slave is no longer disvalued (and disvalue is necessary for a condition to be a mental disorder). This might or might not be independent of scientific evidence. Secondly, it might be that science has shown that drapetomania does not involve anything going wrong with the mind. This might have occurred independently of values, but such a scientific finding might also be influenced by values. That is, that racism is no longer acceptable might influence the conclusion that nothing has gone wrong in the minds of runaway slaves. (It might also be that drapetomania is not a mental disorder because it is neither disvalued nor considered to involve something going wrong with the mind.)

Conceptualising *mental disorder* as a 'disvalued condition in which something has gone wrong with the mind' means that conditions such as homosexuality and drapetomania can be considered mental disorders by some societies but not others. Whether drapetomania is a mental disorder in a certain society depends on both its value-status and science, and these two might not be independent of each other.

[48] It could be argued that Cartwright does not think that drapetomania involves something going wrong with the mind considering that Cartwright says that drapetomania is "the *natural* offspring of negro liberty" and "when left to himself, the negro indulges in his *natural* disposition to idleness and sloth" (Cartwright, 1851/2004, 36, my emphasis). However, this would presume that natural mental dispositions cannot be mental disorders which is spurious.

In addition to claiming that drapetomania is a mental disorder, Cartwright also claims that because it is a mental disorder, a runaway slave should be treated in such a way that they return to slavery. Cartwright claims that if a slave runs away (or attempts to), becomes indolent or sees him or herself as an equal to his or her white master, then both for the sake of humanity and the slave's own good, the slave "should be punished until they fall into that submissive state which it was intended for them to occupy" (Cartwright, 1851/2004, 35). He sees this as being a good outcome for the slave—considering the slave to be mentally disordered is preferable to saying that the slave is being a "rascal" (Cartwright, 1851/2004, 37) or that the slave is being intentionally mischievous (Cartwright, 1851/2004, 36).

The treatment that Cartwright suggested for drapetomania is to stimulate the liver, kidneys and skin to activity. The best way of doing so is to

> to anoint [the skin of a drapetomaniac] all over with oil, and to slap the oil in with a broad leather strap; then to put the patient to some hard kind of work in the open air and sunshine, that will compel him to expand his lungs (Cartwright, 1851/2004, 37).

Readers from the developed world might well see this technique as punishment. Cartwright also thinks of this as a form of punishment. However, Cartwright also thinks of such punishment as therapeutic i.e. as a form of medical treatment based on "sound physiological principles" (Cartwright, 1851/2004, 35, 37). Whether the whipping of slaves and being given hard work is a medical treatment will be discussed in section 2.1 of chapter four. The point for now is that Cartwright considered it to be medical treatment. Chapter four shows that the medical treatment of mental disorders is appropriate. As Cartwright considered drapetomania to be a mental disorder, the medical treatment of drapetomania was appropriate. While it is odd to think of whipping runaway slaves as appropriate medical treatment, this does not mean that it was acceptable or effective. As drapetomania is not considered to be a mental disorder in the developed world, the medical treatment of drapetomania is not appropriate – or at least the appropriateness of the medical treatment of drapetomania is debatable.

As mentioned earlier, one way of showing that runaway slaves should not be medically treated (i.e. whipped) is to show that the treatment is ineffective, harmful or not consented to. Cartwright claimed that the treatment was remarkably effective. He said:

> The effect of this or a like course of treatment is often like enchantment … the negro seems to be awakened to a new existence, and to look grateful and thankful to the white man whose compulsory power, by making him inhale vital air, has restored his sensation and dispelled the mist that clouded his intellect … [He is] a good negro that can hoe or plough, and handle things with as much care as his other fellow-servants (Cartwright, 1851/2004, 37).

Even if the course of treatment were effective – even if the runaway slave did become a 'good negro' by Cartwright's standards – it is arguable that being a good slave is not a desirable end. This would mean that the medical treatment did not benefit the slave. By analogy, even if conversion therapy for gay people were effective, it is arguable that making a gay person straight might not benefit the patient (i.e. the person who was previously gay). While there is no evidence, it is highly likely that the whipping and so on of runaway slaves was harmful – it might have led to physical harms such as welts and infections; as well as mental afflictions such as depression or uncontrollable anger. Of course, Cartwright would claim that the harms caused by the course of treatment were outweighed by what he saw as the benefits thereof – that the runaway became a good slave. On the other hand, those of us in the developed world will argue that being a good slave confers no benefit to the slave, and so the harm caused by whipping the slave is cannot be outweighed by the benefit. Finally, while there is no information regarding whether runaway slaves consented to being whipped and so on, it is very unlikely that the slaves would have consented.

To summarise, Samuel Cartwright claimed that being a runaway slave, an indolent slave or a slave who saw him or herself as equal to his or her white master was a mental disorder. The whipping of runaway slaves (and putting them to hard work) appears to readers from the developed world to be a straightforward case of corporal punishment, not medical treatment. However, I have argued that Cartwright thought of punishing the runaway slaves as medical treatment – he said it was based on sound physiological principles. This section highlights that in societies that consider drapetomania to be a mental disorder, drapetomania was medically treated i.e. it was appropriate to

medically treat drapetomania. Nowadays, we do not classify drapetomania as a mental disorder. Hence, we do not think the medical treatment of drapetomania is appropriate.

3.3 Masturbation

In the eighteenth and nineteenth centuries, masturbation was thought to cause a wide range of physical disorders such as blindness, epilepsy, acne and rickets (Engelhardt, 1974). In addition, Tissot, an eighteenth century Swiss physician, argued that losing semen was equivalent to losing blood and so semen should not be lost unnecessarily i.e. ejaculation should only occur in aid of procreation. Tissot also claimed that when a man ejaculates in the recumbent position (which according to Tissot is typical in masturbation) more semen is lost, which makes masturbation riskier to one's health than ejaculation during intercourse (Engelhardt, 1974, 235). Tissot's analysis only applies to men, yet masturbation was considered a mental disorder for both men and women. In women, masturbation was thought to led to yellowish vaginal discharge, reddened and congested labia majora and elongation of the labia minora (Engelhardt, 1974, 236).

In addition to the claim that masturbation caused physical disorders, masturbation was also thought to cause mental disorders i.e. 'general mental decay' (Graham in Whorton, 2001, 67; see also Hare, 1962). In 1834, Graham, a Presbyterian minister, gave a lecture to young men in which he warned that ongoing masturbation leads to 'general mental decay' to the point at which

> the wretched transgressor sinks into a miserable fatuity, and finally becomes a confirmed and degraded idiot, whose deeply sunken and vacant glassy eye, and livid, shrivelled countenance, and ulcerous, toothless gums, and fetid breath, and feeble broken voice, and emaciated and dwarfish and crooked body, and almost hairless head—covered, perhaps, with suppurating blisters and running sores—denote a premature old age—a blighted body—and a ruined soul! (Graham in Whorton, 2001, 67).

It is plausible that Graham was influenced by the prudish moral values roughly around the Victorian era[49]—Graham thought that all pleasurable sensations were satanic temptation in disguise so that it was not only those who masturbated that suffered the

[49] It is not the case that as soon as Victoria came to the throne prudishness often referred to as 'Victorian' emerged. Instead, Victorian prudishness began to emerge before she become Queen.

ill-effects of stimulation; those who ate meat, drank whisky or chewed tobacco were also damaging their body (Whorton, 2001, 67).

Another reason that the idea that masturbation caused insanity gained favour was that in the increasing number of mental asylums, many patients were observed masturbating—the classic 'correlation equals causation' fallacy was made (Whorton, 2001, 66; Hare 1962, 11-12). In addition, Hare has pointed out that the idea that madness was caused by evil spirits had fallen out of favour, and so people were on the lookout for the 'real' cause of insanity (Hare, 1962, 11).

Masturbation (i.e. the inability to refrain from masturbating) is also considered to be a mental disorder in itself (Engelhardt, 1974). While Engelhardt does not explain why masturbation was considered to be a mental disorder, this is likely because masturbation was thought to lead to physical disorders and general mental decay. By analogy, it might be that anorexia is currently classified as a mental disorder because it leads to physical disorders and death.[50] As with homosexuality and drapetomania, I work on the presumption that the intension of *mental disorder* was the same during the eighteenth and nineteenth centuries as it is now. If correct, this means that those in the eighteenth and nineteenth centuries must have thought that the inability to refrain from masturbating (being a mental disorder) was caused by something going wrong with the mind, and also that masturbation was disvalued.

By the beginning of the twentieth century, the idea that masturbation caused insanity and was itself a mental disorder had fallen out of favour (Engelhardt, 1974; Hare, 1962, 12-13).[51] If my claim that 'mental disorders are disvalued conditions of the mind in which something has gone wrong' is correct, then either masturbation was no longer disvalued and/or it was no longer thought to involve something going wrong with the mind. Hare gives four reasons for the downfall of the notion of masturbation as a mental disorder (Hare, 1962, 12-15). The first is the acknowledgement of the role of the causation/correlation fallacy; the second that masturbation was found to be very common and the proportion of insane people was much smaller than the proportion of those who masturbated. As Doctor J. W. Robertson pointed out, if masturbation caused

[50] On this approach, over-eating might also be classed as a mental disorder if it leads to physical disorders. Alternately, masturbation might have been seen as a 'compulsive' mental disorder akin to an obsessive compulsive disorder.
[51] *C.f.* for example, D.H. Lawrence (Cowan, 1995 and Stoehr, 1975, 111).

insanity, then the capacity of state asylums would need to increase tenfold. Whorton adds that, as some psychiatrists presumably masturbate, some of the potential inmates would be psychiatrists (Whorton, 2001, 68). Hare's third reason is that it is hard to know whether a patient has masturbated or not—those who admitted to it were believed, those that denied it were not. Physicians became wary of this rule of thumb, and so began to question whether masturbation caused insanity. Hare's final reason is that the physiological processes fell into question—why is masturbation more damaging than intercourse?

Hare's final reason suggests that 'masturbation as mental disorder' fell out of favour, in part, because masturbation was no longer thought to involve something going wrong with the mind.[52] Of course, as explained in section 3.1.1 of this chapter, descriptive and evaluative claims might not be independent of each other. Hence, it might be that the physiological processes were questioned because the value-status of masturbation was beginning to change. Alternately, it might be that the value-status of masturbation changed after the physiological processes were questioned. Despite this, none of the reasons given by Hare directly refer to the idea that masturbation was no longer thought of as a mental disorder because masturbation was no longer disvalued.[53] Perhaps this is because, in the 1960s, when Hare was writing, masturbation was still largely disvalued. In any case, Engelhardt hints at the change in value-status in his 1974 article. He suggests that masturbation was considered to be a mental illness because of "particular cultural norms … which had no essential basis in biology" (Engelhardt, 1974, 243). That is, there were some people who considered the damaging effects of masturbation to be the consequence of living in a society that condemned masturbation i.e. that guilt caused the downfall associated with masturbation. If guilt, not masturbation, caused that downfall, then there might be no reason to disvalue masturbation.

[52] Boorse claims all diseases or mental disorders must be statistical abnormal dysfunctions (Boorse, 1975). Hare's second reason why 'masturbation as mental disorder' fell out of favour (i.e. that masturbation is very common) suggests that masturbation cannot be a statistically abnormal dysfunction i.e. that it does not involve something going wrong with the mind.

[53] Hare claims that the masturbatory hypothesis was an inevitable outcome of the very new science of psychiatry (Hare, 1962, 19). Less charitably, the masturbatory hypothesis may be the outcome of the infiltration of prudish values into medicine and psychiatry.

In summary, masturbation is a mental disorder in societies that both disvalue masturbation and consider it to involve something going wrong in the mind. (These two criteria might not be independent of each other.) Nowadays, masturbation is not considered to be a mental disorder which means that at least one of these criterion is not fulfilled. The take home message from this section is that masturbation might be a mental disorder in one society but not another.

The medical treatment of masturbation began in the nineteenth century. Prior to this, there were very few, if any, medical treatments available to treat masturbation.[54] Moreover, in the eighteenth century, it was thought that explaining the ill-effects of masturbation should be sufficient to stop a person from masturbating and if they did not, then they only had themselves to blame for the ensuing insanity (Hare, 1962, 10). By the nineteenth century, treatment included applying camphor or cantharides (an aphrodisiac!) to the genitals (Hare, 1962, 10). In the second half of the nineteenth century, mechanical devices to make masturbation difficult were being used, as was the burning of genitals, vasectomies, circumcision, clitoridectomies and even castration[55] (Engelhardt, 1974; Hare 1962). As late as the 1880s, an American doctor was urging parents to try to catch their children masturbating and then to circumcise or perform a clitoridectomy on the child without the benefit of an anaesthetic (Whorton, 2001, 67).

While some people (or their parents) might have consented to this treatment, it is likely that this is not always the case. It is also likely that some of the medical treatments were effective. For example, if a man's penis were castrated (i.e. cut off), this would effectively stop him from masturbating. Even so, it is a separate question whether such a castration treatment benefited the patient. To readers from the developed world, it seems clear that such treatments could not have benefitted the patient – that the treatments are cruel or harmful seems to be without question. However, Hare points out that someone who believed in the masturbatory hypothesis (i.e. that masturbation could cause insanity and a plethora of physical ailments) was obliged to take such steps to prevent

[54] That is, it is highly likely that homosexuality was not medically treated because there was no effective medical treatment i.e. it is highly unlikely that homosexuality was not medically treated because medical treatment thereof was considered inappropriate.

[55] While Engelhardt uses the term CASTRATION, it does not appear that men's penises were cut off. Instead, Haynes (the surgeon cited by Engelhardt) removed a duct from the penis.

masturbation, at least insofar as the harm it caused was outweighed by the benefit (Hare, 1962, 11).

To summarise, masturbation is medically treated in many societies in which it is thought to cause mental or physical disorders, or is thought of as a mental disorder in itself. In the developed world, masturbation is not considered to be a mental disorder, and so the appropriateness of the medical treatment of homosexuality is questionable.

3.4 Sluggish schizophrenia

During the 1960s and 1970s in Soviet Russia, some political dissidents were considered to have subclinical[56] manifestations of schizophrenia. These manifestations included having reformist delusions, or put bluntly, opposing the government (Smulevich, 1989; Fulford *et al.,* 1993). I work on the presumption that Soviet Russians had the same intension of *mental disorder* as currently used – mental disorders are disvalued conditions in which something has gone wrong with the mind. This means that Soviet Russians must have both disvalued being a political dissident and thought that it involved something going wrong with the mind.

During the 1960s and 1970s, western psychiatrists might have considered these patients to have subclinical manifestations of schizophrenia, whereas Soviet psychiatrists deemed these manifestations to be a diagnosis in itself, namely, sluggish schizophrenia (Fulford *et al.,* 1993). The rationale for the Soviet position was, given that the Soviet Russian's had the best political system in the world, there could be no logical reason for opposing the regime, and thus the dissidents must be mad. That is, it was thought that to disagree with the Soviet political regime was evidence that the dissident must have a mental dysfunction. This suggests, as mentioned in the previous sections, that there is an interplay between facts and values. That is, the idea that being a political dissident involved something going wrong with the mind is influenced by the value-status of being a political dissident i.e. that being a political dissident is disvalued. (It is possible that the claim that being a political dissident involves something going wrong

[56] That is, these manifestations were insufficient to give a diagnosis of schizophrenia, but were clinical manifestations in the sense that they were sufficient to give a diagnosis of sluggish schizophrenia. By analogy, the manifestations may have been clinical in the sense that they would have been sufficient to diagnose the now abandoned condition of Attenuated Psychosis Syndrome (see section one of chapter one) but not schizophrenia itself.

with the mind influenced the value-status of being a political dissident. However, this is highly unlikely.)

The situation (that to disagree with the Soviet political regime was evidence that the dissident must have a mental dysfunction) was not as overt as I have portrayed. Complex and reasonable arguments were formed to show that the political dissidents had genuine signs of schizophrenia. Moreover, as Bonnie points out, whether a dissident[57] had a genuine mental illness was particularly contestable in cases in which "culturally embedded features of psychopathology are taken into account" (Bonnie, 2002, 136). Even so, it is well accepted that the mental disorder of sluggish schizophrenia was invented to serve the needs of the Soviet government. After reviewing the literature, Merskey and Shafran conclude that the diagnosis of sluggish schizophrenia might be "genuine" (Merskey & Shafran, 1986, 247) but that

> under the influence of an unscrupulous regime the observations put forward could serve as a ready means to label as psychotically ill many energetic and capable citizens who were in disagreement with authority … They allow for psychiatric disposal, without much other justification, of anyone whose social activism is unacceptable to the psychiatrist who believes in the officially approved system (Merskey & Shafran, 1986, 254).

Wilkinson claims that sluggish schizophrenia was a diagnosis hardly seen outside of the Eastern bloc (Wilkinson, 1986, 641; see also Merskey & Shafran, 1986). However, Fulford *et al.* argue that at the time, both the Eastern bloc and USA had broad criteria for schizophrenia and following Wing, claim that sluggish schizophrenia is similar to the western construct of latent schizophrenia. Moreover, Fulford *et. al.* point out that although some Russian patients examined by western doctors were not suffering from schizophrenia, they had other mental disorders such as manic or depressive psychosis or neurotic depression (Fulford *et al.*, 1993, 804). (Fulford *et al.* (1993) do not disagree that psychiatry was used for political purposes in the USSR but argue that this was allowed both by bad science and an unwillingness to acknowledge the values within psychiatry.)

In the developed world, a person cannot be diagnosed with sluggish schizophrenia solely on the basis that he or she is a political dissident. In addition, in the developed

[57] Bonnie refers to both political and religious dissidents of the USSR.

world, a person cannot be diagnosed with latent schizophrenia (the western equivalent of sluggish schizophrenia) solely on the basis that he or she is a political dissident. In the developed world, being a political dissident is insufficient to show that somebody has a mental disorder. This is supported by the *DSM*'s definition of *mental disorder* in which deviant behaviour (including political deviance) is not a mental disorder unless it is a symptom of a dysfunction in the individual.[58] Moreover, in New Zealand, a person is not subject to compulsory assessment or treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 based solely on his or her political beliefs. Based on my claim that all mental disorders are disvalued conditions in which something has gone wrong with the mind, this means that in the developed world being a political dissident is not disvalued and/or is not evidence of something going wrong in the mind.[59]

To summarise so far, in Soviet Russia, some political dissidents were classed as being mentally disordered (specifically, they were said to have sluggish schizophrenia). In the developed world, we do not think people should be diagnosed with sluggish or latent schizophrenia solely on the basis that they are political dissidents. Being a political dissident might be a mental disorder in one society but not another. Whether being a political dissident is a mental disorder depends on its value-status and science (i.e. whether it is considered to be caused by something going wrong with the mind) and these two might not be independent of each other.

Sluggish schizophrenics (i.e. those political dissidents diagnosed with sluggish schizophrenia) were given psychotropic medication, shock treatment and confined to long-term institutionalisation (Adler & Gluzman, 1993; Jargin, 2011, 117). Institutionalisation effectively meant that those who opposed the government could not disseminate their political views, which in turn meant that the public would not be influenced by these minority views. Adler and Gluzman (1993) also document the atrocious conditions of the institutions—over-crowding, lack of personal hygiene and food, physical constraints and monotony, physical punishment (sometimes causing

[58] This definition was first used in the *DSM-III* and is still used in the *DSM-5.*

[59] Moreover, the two may not be independent of each other – that being a political dissident is not disvalued may influence the finding that it does not involve something going wrong with the mind, or that being a political dissident does not involve something going wrong with the mind influences the value-status of being a political dissident.

death), isolation and the open-ended term of institutionalisation. Pharmacological treatment included giving patients Sulfazin (which caused intense muscular pain), Atropine (which can cause toxic psychosis), insulin coma therapy (which sometimes led to permanent brain damage) and neuroleptics. This medical treatment was justified on the basis that being a political dissident was considered to be a mental disorder (Adler & Gluzman, 1993; Jargin, 2011, 117). As will be argued in chapter four of this thesis, the medical treatment of mental disorders is appropriate which means that in Soviet Russia, the medical treatment of political dissidents (on the basis that they had sluggish schizophrenia) was appropriate.

It is highly unlikely that the political dissidents consented to any of this treatment. That is, it is highly unlikely that the political dissidents agreed that they had the mental disorder sluggish schizophrenia, and so consented to the medical treatment on this basis. This treatment did more harm than good, even once the political dissidents were released from the institution. Adler and Gluzman cite evidence that many dissidents experienced insomnia, depression, isolation and drinking to oblivion (although others have expressed themselves in a more positive way such as through art and music). Moreover, Adler and Gluzman point out that the long-term effects are likely to be much more severe than this but go unreported since people who have been subject to brutality might not come forward with their stories (Adler & Gluzman, 1993, 714).[60] On the other hand, from the Soviet perspective, if the treatment cured or ameliorated the so-called mental disorder of sluggish schizophrenia, then it would have been considered to have done more good than harm.

In summary, some political dissidents within the USSR were considered to be mentally ill solely on the basis of their political beliefs. These people were subject to long-term, open-ended institutionalisation and harmful, inhumane pharmacological treatment. This treatment was justified on the basis that sluggish schizophrenia was a mental disorder. Nowadays, we do not think being a political dissident is sufficient to diagnose someone as being mentally disordered. Hence, the appropriateness of medically

[60] Adler and Gluzman (1993) interviewed twenty-two people who were committed to psychiatric institutions solely because they held unofficial political views (as ratified by the World Psychiatric Association, American Psychiatric Association and other experts).

treating a person solely on the basis that he or she has minority political beliefs is extremely questionable.

4. Conclusion and analysis of the four case studies

The previous sections considered four case studies, namely, homosexuality, drapetomania, masturbation and sluggish schizophrenia. I have worked on the presumption that the intension of *mental disorder* is the same across all the societies considered. For homosexuality, drapetomania, masturbation or sluggish schizophrenia to be mental disorders in the relevant society, they must be disvalued conditions in which something has gone wrong with the mind. While these conditions have all been considered to be mental disorders in different societies, they are no longer considered to be mental disorders in the vast majority of the developed world.[61] This means that the conditions are no longer a) disvalued and/or b) considered to involve something going wrong with the mind. Section three also explained that the evaluative claim and descriptive claim (i.e. whether something has gone wrong with the mind) might both influence each other, and for this reason, it can be difficult to pinpoint why a condition is or is not considered to be a mental disorder.

There are two main points to be taken from the four historical case studies. The first is that whether a condition is considered to be a mental disorder changes depending on the society in question. That is, even if the intension of *mental disorder* does not change between societies, whether a condition is disvalued can change between cultures. Equally, whether a condition is considered to involve something going wrong with the mind can change between cultures. In turn, the disorder-status of a condition might also change over cultures. In more technical terms, the case studies show that even if the intension of *mental disorder* is the same for all societies, then extension of *mental disorder* might change. For example, homosexuality can fall within the extension of *mental disorder* for one society, but not fall within the extension thereof for another society.

The second point highlighted by the four case studies is that in societies in which these conditions were considered to be mental disorders, the conditions were medically

[61] While schizophrenia is still considered by many to be a mental disorder, it cannot be diagnosed solely on the basis of being a political dissident.

treated. Chapter four will show that these conditions were medically treated on the basis of being mental disorders i.e. that the medical treatment of these conditions was appropriate because the conditions were considered to be mental disorders. In this chapter, all I wanted to show was that it appears to be the case that by classifying a condition as a mental disorder, the medical treatment of that condition is appropriate. This is a descriptive claim. I am describing what seems to be the case, rather than saying this ought to be the case.

In short, the case studies show that even if the intension of *mental disorder* can be applied to all societies in question, the extension of *mental disorder* can change from society to society. In turn, because the extension of *mental disorder* is relative to the society in question, whether a condition can be medically treated on the basis of being a mental disorder is relative to the society in question.

Looked at from the perspective of the developed world, it seems abhorrent that homosexuality, drapetomania, masturbation and sluggish schizophrenia could be considered to be mental disorders. In addition, that these conditions were medically treated seems even more repugnant. It seems that these are examples in which medical treatment is used for the purpose of social control. From the point of view of the developed world, it would be beneficial if it could be shown that these conditions are not mental disorders in any society, as this would mean that people with these conditions could not be medically treated on the basis of being mentally disordered in any society. For example, if the extension of *mental disorder* did not change relative to the society in question, then it could be determined, for once and for all, whether homosexuality is a mental disorder and whether it may be medically treated on the basis of being a mental disorder. Equally, if the extension of *mental disorder* did not change relative to the society in question, it could be determined, for once and for all, whether drapetomania, masturbation and being a political dissident are mental disorders, and whether they may be medically treated on the basis of being mental disorders. For this reason, this thesis considers whether it is possible for the extension of *mental disorder* to be static between societies.

I am not the first person to consider whether the extension of *mental disorder* is static between societies. Brülde asks whether there is "a single correct way to draw the line between the pathological and the non-pathological" or whether there are multiple ways

of drawing that line that are equally correct (Brülde, 2005, 2).[62] However, Brülde (2010) concludes that there are multiple correct ways of drawing the line.

It might be pointed out that since we do not currently consider homosexuality (and the other conditions explored in the case studies) to be a mental disorder, there is no need to ascertain whether the extension of *mental disorder* is static between societies – all that matters is that we now have the correct extension. There are two problems with this line of argument. Firstly, it does not prevent the extension of *mental disorder* from changing in such a way that it includes homosexuality and so on.[63] This would mean that homosexuality and so on may be medically treated on the basis of being mental disorders, and this is the very thing that many people, including myself, want to safeguard against. Secondly, there exist conditions for which it is a matter of debate whether they fall within the extension of *mental disorder*. For example, while Attention Deficit Hyperactivity Disorder (ADHD) is currently considered to be a mental disorder and is included within the *DSM*-5, there are academics who argue that ADHD is not a mental disorder (Singh, 2008; 2002; Timimi and Taylor, 2004; Conrad and Potter, 2000). They claim that ADHD is not a scientifically valid diagnosis but is instead a cultural construct.

I work on the basis that all mental disorders must be disvalued conditions in which something has gone wrong with the mind. Hence, those who claim that ADHD is not a mental disorder must either show that ADHD is not to be disvalued and/or that ADHD does not involve something going wrong with the mind. Mather is of the opinion that ADHD is not always to be disvalued – that hyperactivity can be a positive trait (Mather, 2012, 19). Mather quotes Hartmann's (2003) argument that Thomas Edison had ADHD-like symptoms but Edison was able to use this in a beneficial way. Others claim that it is not clear that ADHD involves something going wrong with the mind. Timimi (2003) says that none of the thirty neuroimaging studies published (as at 2003) have shown that the brains of those diagnosed with ADHD are clinically abnormal[64], and that it cannot be determined whether the differences in the brains of those with ADHD are caused by

[62] Nordenfelt says that the most crucial question regarding the health-concepts (e.g. *health, disease* and *disorder*) is whether there is only one concept of health and one concept of disease (Nordenfelt, 1995, 6; see also Nordenfelt, 1997, 16-17). However, Nordenfelt focuses on the intension of *mental disorder* rather than the extension thereof.
[63] That is, even if the intension of *mental disorder* remains the same, the extension may change in this way.
[64] 'Clinically abnormal' is the phrase used by Timimi.

(rather than being the cause of) different thinking styles or taking medication such as Ritalin. She also points out that co-morbidity is extremely high which makes doubtful the claim that ADHD is a distinct mental disorder.[65] Finally, Timimi claims that while methylphenidate (Ritalin) is widely used to treat those with ADHD, it has similar effects on those without ADHD. Ritalin has also generated huge profits for the pharmaceutical industry which might have tempted 'big pharma' to conceptualise ADHD as a mental disorder i.e. to conceptualise ADHD is involving something going wrong with the mind.

Many of those who claim that ADHD is not a mental disorder also claim that medically treating those diagnosed with ADHD is a form of social control (Norris and Lloyd in Mather, 2012, 19). Conrad, a stalwart of those who think ADHD is not a mental disorder, agrees with Lennard that "psychoactive drugs, especially those legally prescribed, tend to restrain individuals from behavior and experience that are not complementary to the requirements of the dominant value system" (Lennard in Conrad, 2006, 73). Put into my terminology, if ADHD is not a mental disorder, then it may not be medically treated on the basis of being a mental disorder – medically treating those with ADHD would not be appropriate. Considering ADHD to be a mental disorder and medically treating it on this basis would be akin to medically treating homosexuality (or masturbation, being a runaway slave or being a political dissident) on the basis that it is a mental disorder. That is, the treatment of ADHD might be seen as an unjustified form of social control; of medicine being used as a guise for constraining the behaviour of non-conforming people.

As shown by the four historical case studies, as the intension of *mental disorder* is 'a disvalued condition of the mind in which something has gone wrong', the extension of *mental disorder* might change between societies. ADHD might be a mental disorder in the developed world, but might not have been a mental disorder in a hunter-gatherer society (Mather, 2012, 19). This might be beneficial insofar as it allows the extension of *mental disorder* to be tailored to the society in question. On the flipside, the disadvantage of this approach is that considering someone to be mentally disordered

[65] Similarly, even though schizophrenia is currently considered to be a mental disorder and is included within the *DSM*-5, Bentall (1993) and Boyle (1990) argue that schizophrenia is not a mental disorder. They argue that the concept *schizophrenia* does not meet the standards of scientific validity (Poland, 2007, 170) and instead see schizophrenia as "a complex, dynamic, multi-level, interactive, and normatively constituted domain of phenomena" (Poland, 2006, 108).

could be used as a form of social control. Almost any disvalued mental state could can be considered to be a mental disorder, and medically treated (sometimes without consent) on this basis. Moreover, the judgment regarding whether 'something has gone wrong with the mind' might well be influenced by values. For example, homophobic people (those who maintain that homosexuality is to be disvalued) might be inclined to find that homosexuality does involve something going wrong with the mind, whereas queer-friendly people, like myself, might be inclined to the conclusion that homosexuality does not involve anything going wrong. This means that even though to be a mental disorder a condition must involve something going wrong with the mind, this might be insufficient to safeguard against mental disorder being used for the purpose of social control.

In contrast, if the extension of *mental disorder* were fixed between societies, then we could not consider (almost) anything we wanted to be a mental disorder. That is, there would be a truth about what is or is not a mental disorder. In turn, psychiatric medicine could not be used as a guise for social control. There would be a truth concerning whether a condition is a mental disorder, and in turn there would be a truth about whether that condition may be medically treated on the basis of being a mental disorder. It could be determined whether ADHD is a mental disorder. If ADHD is not a mental disorder, then it may not be treated on the basis of being a mental disorder. Those who medically treated ADHD on the basis of being a mental disorder would be using medicine for the purpose of social control. On the other hand, if ADHD is a mental disorder, then it may be medically treated on the basis of being a mental disorder. Those who claim that prescribing medications such as Ritalin is a form of social control would be wrong.[66]

Looking at the big picture, if a) mental disorders may be medically treated (on the basis of being mental disorders), and b) the extension of *mental disorder* is relative to the

[66] Both schizophrenia and ADHD are examples of conditions that are considered to be mental disorders in the developed world. There are also examples of conditions that are not currently considered to be mental disorders, but there is argument that they should be. For example, as mentioned in section 3.2, the grief that occurs once a loved-one has died is not normally classified as a mental disorder. (There is a clause in the *DSM's* account of major depressive disorder that excludes depression caused by recent bereavement.) However, Engel, Bowlby and Hofer all claim that post-bereavement grief may be a mental disorder (Engel, Bowlby and Hofer in Kopelman, 1994 *c.f.* Kopelman, 1994 and Wakefield, 2012a). To use my terminology, if post-bereavement grief is both disvalued and caused by something going wrong with the mind, then it would be a mental disorder.

society in question, then it follows c) that a condition may be medically treated in societies that classify as a mental disorder but that same condition may not be medically treated (on the basis of being a mental disorder) in societies that do not classify it as a mental disorder. This leaves psychiatry vulnerable to being used for the purpose of social control. In contrast, if the extension of *mental disorder* is static, then it becomes much more difficult to use psychiatry as a guise for social control. Instead, it could be determined, for once and for all, whether a condition is a mental disorder, and whether it may be medically treated on the basis of being a mental disorder.

Chapter Three – Ways of showing that a condition should not or may not be medically treated

1. Introduction

The previous chapter suggested that mental disorders are those disvalued conditions in which something has gone wrong with the mind. It also showed that even if the intension of *mental disorder* can be applied to all societies, the extension of *mental disorder* can change from society to society. A condition can be a mental disorder in one society but not in another. For example, even though homosexuality and post-bereavement grief are not considered to be mental disorders in the developed world, they might be considered to be mental disorders in other societies. The previous chapter also alluded to the idea that there is a link between mental disorder and medical treatment. Considering a condition to be a mental disorder signifies that medical treatment is appropriate, and excluding a condition from being classified as a mental disorder signifies that medical treatment is inappropriate, or at least, that the appropriateness of the medical treatment of that condition is in doubt. Given that a) the extension of *mental disorder* is relative to the society in question, and b) there is a link between mental disorder and medical treatment, it follows that whether a condition may be medically treated on the basis of being a mental disorder is also relative to the society in question.

From the perspective of those of us in the developed world, it is repugnant to think that homosexuality (and drapetomania, masturbation and sluggish schizophrenia) were a) considered to be mental disorders and b) medically treated on the basis of being mental disorders. There are at least three ways of showing that a condition (such as homosexuality, drapetomania, masturbation or sluggish schizophrenia) should not or may not be medically treated. The first is to show that these conditions should not be medically treated because the standard bioethical criteria for acceptable medical treatment, namely, benefit to the patient, harm-minimisation, and consent, are not in favour of medical treatment. (This section also considers whether it can be shown that homosexuality and so on should not be medically treated according to Fulford's (2004a) values-based medicine.) The second way of showing that a condition such as homosexuality may not be medically treated is to show that the condition in question is

not a disorder, and that only disorders may be medically treated. The third way of showing that these conditions may not be medically treated is to show that a) the condition in question is not a mental disorder and b) only mental disorders may be medically treated on the basis of being mental disorders i.e. that the rhetoric of mental disorders can only be used to justify the medical treatment of mental disorders. This chapter discusses each of these three options in turn.

Another way in which it could be shown that homosexuality and so on should not be medically treated is to show that the medical treatment thereof is contrary to the ethos of medicine.[67] However, even if there is agreement between societies regarding the ethos of medicine, it does not follow that there will be agreement about whether homosexuality and so on should be medically treated. This is because there is a diverse range of values concerning mental states (Fulford, 1995, 155; 1993, 159).[68] Hence, whether the treatment of homosexuality falls within the ethos of medicine might be an intractable debate. This approach is not considered in more detail for practical reasons. Such an approach would require an examination of the ethos of medicine, which could not be adequately discussed within the space constraints of this thesis. Instead, the thesis focuses on whether the extension of *mental disorder* can be invoked to safeguard against the medical treatment of homosexuality. Furthermore, the thesis largely steers clear of the 'values' debate (i.e. whether homosexuality etc. are to be disvalued) in order to drill down as far as possible on whether there is a static extension of *mental disorder*.

Before these three options are discussed, two notes regarding terminology need to be made. Firstly, to refer to both physical and mental disorders, I use the term DISORDER. To refer solely to mental disorders, I use the term MENTAL DISORDERS. (As explained in section 1.1 of chapter one, I consider all mental disorders to be disorders.) As it is the case that physical disorders may be medically treated, it is wrong to claim that 'only mental disorders may be medically treated'. Hence, section two of this chapter considers the claim 'only disorders may be medically treated'. Equally, section one considers whether disorders may be medically treated.

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[67] This approach was suggested by the internal examiner.

[68] Note that while Fulford requires examining the values of all involved parties, Fulford does not claim that VBM will always come to a consensus (Fulford, 2004, 64; see the coda of chapter nine).
See also Wakefield, 1992, 386; 1993, 162; 2014, 675.

The second terminological note relates to the difference between the terms MAY and SHOULD. This will be discussed in detail in the following chapter. To say that some condition SHOULD be medically treated is a prescriptive, action-guiding claim. In contrast, to say that a condition MAY be medically treated is not a prescriptive claim. Instead, it means that medical treatment for that condition is appropriate i.e. that it makes sense to medically treat that condition. SHOULD and MAY do not mean the same thing - there are cases in which medical treatment can be appropriate but should not be given. Nor do SHOULD NOT and MAY NOT mean the same thing. If a condition may not be medically treated, then it is inappropriate to treat it. In contrast, to say something should not be medically treated means it is immoral to treat it.

2. Disorders and non-disorders should be medically treated according to the standard bioethical criteria/Values-Based Medicine

One way of showing that that a condition (such as homosexuality, drapetomania, masturbation or sluggish schizophrenia) should not be medically treated is to show that the established ethical criteria relevant to clinical decision-making are not in favour of medical treatment. It is arguable that much of the medical treatment outlined in the four historical case studies was harmful, not beneficial and not consented to, which suggests that the proposed medical treatment should not have been given.[69] That is, the balance of the criteria is unfavourable to giving medical treatment.[70] These criteria for determining whether medical treatment is acceptable apply to both disorders and non-disorders. For example, these criteria apply, to both chemotherapy for cancer (a physical disorder), and to pain relief during labour (which is not a disorder). Whether a condition is a disorder (either mental or physical) is irrelevant to whether it should be medically treated on this approach.

[69] These criteria are very similar to Beauchamp and Childress' (2009) 'four principles' approach. On this approach, the principles of beneficence, non-maleficence, autonomy and distributive justice are central to determine whether medical treatment should be given. However, as pointed out by the internal examiner, Beauchamp and Childress' principles are broader than the standard ethical criteria. Hence, the thesis does not refer directly to Beauchamp and Childress' work.

[70] Earp *et al.* claim that the medical treatment of homosexuality might be acceptable so long as the four standard bioethical criteria are met. In fact, Earp et al. go a step further and say that so long as the person understands the risks involved, the proposed treatment neither needs to be totally effective nor totally harmless (Earp *et al.,* 2014, 7).

I acknowledge that whether a medical treatment benefits the patient might be difficult to determine. For example, is the removal of a healthy limb in someone with Bodily Integrity Identity Disorder (BIID) beneficial (Müller, 2009)? In addition, there is a difference between a medical treatment being effective and it being beneficial. For example, providing a lobotomy to a violently psychotic person might be effective insofar as the person might become docile. However, it is debatable whether the lobotomy benefits the patient. Likewise, conversion therapy for gay people might in the future[71] be effective insofar as it makes gay people straight, and cutting off a man's penis is effective insofar as it prevents him from masturbating. Even so, it is debatable whether conversion therapy and castration benefit the patient. Whether a medical treatment minimises harm to the patient might also be debatable. Is the removal of a healthy limb in a person with BIID harmful? Is making a violent person docile harmful? Is preventing a person from masturbation harmful?

Regarding physical conditions, whether a medical treatment is beneficial or not is often much more straightforward. According to Fulford, this is because the values involved in mental conditions are much more diverse than those associated with physical conditions. For example, nearly everyone agrees that a broken arm is a bad thing to have. In turn, nearly everyone agrees that treating a broken arm benefits the patient. In contrast, there is less agreement on the values involved in mental conditions. For example, extreme sportspeople love the rush of adrenalin that comes from anxiety, others hate it (Fulford, 1993, 159). Hence, whether treating anxiety benefits the patient is highly debatable, as well as being dependent on the patient in question. Fulford argues that the diversity of values in mental illness is not because psychiatry is an embryonic branch of medicine. Instead, because mental illness concerns human experience, the values involved are, and always will be, more diverse than in physical illnesses (Fulford *et. al.,* 2005, 78, 80; see also Thornton, 2014).

Rather than pinning down which medical treatment is beneficial, and which is harmful, this thesis simply points out that if it is determined that a certain medical treatment would not benefit the patient and/or does not minimise harm to the patient, then this suggests the medical treatment should not be given. (This would need to be balanced

[71] See Earp *et. al.* (2014).

alongside the other criteria, such as autonomy.) It is, at the very least, arguable that much of the medical treatment outlined in the four historical cases a) was not beneficial, b) did not minimise harm, c) was non-consensual or d) some combination of these. If so, it suggests that the medical treatment should not have been given.

A major problem with using these criteria alone to determine whether medical treatment should be given is that it is arguable that the medical treatment outlined in the four case studies should not have been given even if it were effective, harmless and consensual. For example, imagine that a doctor offers a gay patient a medical treatment that will make the patient straight. The treatment is in the form of a single pill, which has been thoroughly tested and it has been found to have no physical or psychological risks or side-effects in either the short or long-term. The pill is totally effective—it cures (i.e. makes straight) everybody who takes it. Moreover, the patient does not like being gay – he or she thinks that he or she would be benefited by no longer being gay. (In addition, the patient maintains that being gay is harmful, and taking the pill minimises harm.) The doctor offers this pill to his or her patient, but tells the patient that he or she is under no obligation to take it. In fact, the doctor asks the patient to go away and think about it, and then let the doctor know when they have decided whether to take the pill. In such a scenario, the medical treatment would be effective, harmless and consensual. Even so, some people will claim that such medical treatment should not be provided. This is because homosexuality should not be medically treated even if the standard bioethical criteria are met because there is nothing wrong with being gay in the first place. Gupta (2012), for example, claims that having a diverse range of sexual preferences is a good thing, or at least not a bad thing.[72]

In a nutshell, a consequence of using the standard bioethical criteria related to clinical decision-making to show that a condition or way of being should not be medically treated is that it does not show that a specific condition, such as homosexuality, should not be medically treated. Instead, it says the medical treatment should not be given if, on balance, the standard criteria are not in favour of treatment. This approach does not rule out the medical treatment of conditions (such as homosexuality, drapetomania, masturbation or being a political dissident) lock, stock and barrel.

[72] See the coda of chapter nine.

Alternately, it might be that disorders and non-disorders should be medically treated if the instance of the condition in question passes muster on Fulford's (2004a) 'value-based medicine' (VBM). This approach differs from using the established ethical criteria relevant to clinical decision-making (such as consent, benefit and harm-minimisation) to determine whether medical treatment should be given, insofar as it does not take the established criteria to be necessary or sufficient for guiding clinical decision-making, but claims that the values captured by the criteria only pick out a small proportion of the values involved in medicine (see Thornton, in press; 2011). While this approach has generated much positive attention, it is problematic for my purposes as VBM cannot show whether a type of condition – either a disorder or a non-disorder – should be medically treated. This is because VBM looks at the particular situation of the patient concerned to make clinical decisions. It cannot make a global claim about whether homosexuality and so on should be medically treated. In this respect, VBM is in the same position as the 'standard bioethical criteria' approach.[73] Moreover, VBM, like the 'established ethical criteria relevant to clinical decision-making' approach applies to both disorders and non-disorders. That is, a condition – either a disorder or a non-disorder – should only be medically treated if it passes muster according to VBM. Hence, whether a condition such as homosexuality is a mental disorder does not impact on whether it ought to be treated according to VBM.

3. Only disorders may be medically treated[74]

One way of showing that a condition may not be medically treated is to show that the condition in question is not a disorder and that only disorders may be medically treated. The potential advantage of this approach is that it would mean that if homosexuality were not a mental disorder, then it could never be medically treated. This would remain regardless of whether the proposed treatment was beneficial, minimised harm and was consensual (in situations in which consent were required). The main problem with this approach is that it would rule out too much. For example, the Victorian editor of *The Lancet* claimed that pain during childbirth is normal (i.e. not a disorder) and so opposed

[73] The conclusion of this chapter considers whether the fact that neither the 'established ethical criteria relevant to clinical decision-making approach' nor VBM totally rules out the medical treatment of a condition such as homosexuality is an advantage of disadvantage of these approaches.
[74] I do not claim that 'only disorders should be medically treated' but that 'only disorders may be medically treated'. This denotes that medical treatment is appropriate for mental disorders, as opposed to claiming that there is an obligation to medically treat all disorders.

pain relief for women in labour (Boorse, 1987, 383).[75] It is safe to presume that most people will maintain that pain relief may be given to women in labour even if childbirth is not a disorder. The claim 'only disorders may be medically treated' is needlessly strong. There are other, less draconian ways, in which we might be able to show that a condition such as homosexuality may not be medically treated.[76]

4. Only mental disorders may be medically treated on the basis of being mental disorders

As discussed above, the problem with claiming 'only disorders may be medically treated' is that it rules out too much – it means that non-disorders, such as pain during childbirth, may not be medically treated. In this section, I discuss the claim that the medical treatment of non-disorders is appropriate so long as the rhetoric of disorder (either mental disorder or physical disorder) is not used to justify the medical treatment. The following chapter suggests that a condition's being a disorder is sufficient to show that medical treatment may be given (*c.f.* should be given[77]). In this way, the rhetoric of disorder can be used to show that medical treatment may be given i.e. that medical treatment is appropriate. The corollary of this idea regarding the rhetoric of mental disorder is that if some condition is not a mental disorder, then medical treatment cannot be said to be appropriate for that condition on the basis that the condition is a mental disorder. For example, if homosexuality is not a mental disorder, then we cannot say that it is appropriate to medically treat homosexuality on the basis of being a mental disorder – the rhetoric of mental disorder cannot be used to justify the medical treatment of a condition that is not a mental disorder. The same reasoning can be applied to any other condition that is not a mental disorder. That is, if being a runaway slave or hearing voices is not a mental disorder, then the rhetoric of mental disorder may not be used to justify the medical treatment of these conditions. In

[75] Pain relief is an example of medical treatment. The meaning of *medical treatment* is considered in chapter four. While childbirth is not a disorder, if childbirth goes wrong (as occurs, for example, in an obstructed labour), then this may be a disorder.
[76] Section two of the following chapter picks up on the claim that conditions that are not disorders may be medically treated. It shows that non-disorders, such as pain during childbirth may be medically treated, because both childbirth and providing pain relief fall within the Asclepian frame.
[77] The idea that 'only mental disorders may be medically treated on the basis of being mental disorders' does not mean that all mental disorders should be medically treated.

general, only mental disorders may be medically treated on the basis of being mental disorders.

Section two of this chapter introduced a scenario in which a doctor offers a gay patient a medical treatment (in the form of a single pill) that will make the patient straight. Let us now add to that scenario: the doctor informs the patient that homosexuality is a mental disorder (when it is not) and the patient agrees to take the pill at least in part on the understanding that homosexuality is a mental disorder. In this situation, the rhetoric of mental disorder is used to support the medical treatment of homosexuality. The incorrect extension of mental disorder is being used but the rhetoric of mental disorder is correctly applied. There are three ways in which the rhetoric of a condition being a mental disorder can be incorrectly applied. Firstly, the correct extension of *mental disorder* might be wrongly applied. Secondly, the incorrect extension of *mental disorder* might be adopted, but the rhetoric (i.e. the pragmatic link) is correctly applied. Thirdly, the incorrect extension of *mental disorder* might be wrongly applied. It is the second way that I have in mind – incorrectly considering homosexuality to be a mental disorder means that giving medical treatment is incorrectly deemed to be appropriate. Let us now change the scenario so that the doctor makes sure that the patient understands that homosexuality is not a mental disorder (and it is not), but that the reason the pill is being offered is that the doctor knows that the person lives in a very homophobic community or that the person themselves is deeply unhappy with their sexuality. In this scenario, the rhetoric of mental disorder is not used to justify the medical treatment of homosexuality.

As will be discussed in the conclusion of this chapter, some people will argue that the pill should not be offered even though the doctor is clear that homosexuality is not a disorder. Yet, some people, myself included, maintain that it would be acceptable to offer the patient the pill, so long as the doctor is clear that homosexuality is not a disorder. The important point for now is to explain the notion of the rhetoric of mental disorder i.e. that only mental disorders may be medically treated on the basis of being mental disorders. The claim ‘only mental disorders may be medically treated on the basis of being mental disorders’ is quite different from the claim ‘only disorders may be

medically treated'.[78] The latter makes the strong claim that conditions that are not disorders (either mental disorders or physical disorders) may never be medically treated. The former claim is weaker insofar as conditions that are not mental disorders may be medically treated, but that the rhetoric of mental disorder cannot be used to justify the medical treatment of these conditions.

5. Conclusion: Advantages and disadvantages of each approach

From the perspective of the developed world, it is repugnant to think that homosexuality, drapetomania, masturbation and sluggish schizophrenia were medically treated on the basis of being mental disorders. This chapter has considered three ways in which it might be shown that these four conditions should not or may not be medically treated.

The first was to show that these conditions should not be medically treated if a) the standard bioethical criteria (benefit to the patient, harm-minimisation, and consent) are not in favour of medical treatment, or b) the treatment does not pass muster according to VBM. The main consequence of both these approaches is that they do not totally rule out the medical treatment of homosexuality, drapetomania, masturbation and sluggish schizophrenia. This is because the standard criteria and VBM do not determine whether a type of condition (e.g. homosexuality, schizophrenia) should be medically treated, but determines whether a particular medical treatment should be given to a particular individual. On both these approaches, whether the condition in question is a disorder is irrelevant. A further consequence of these approaches is that neither entirely rules out the medical treatment of, for example, homosexuality. Whether this is an advantage or a disadvantage of this approach is debatable. It is disadvantageous insofar as it will not prevent the medical treatment of homosexuality. It is advantageous insofar as the medical treatment of homosexuality in certain circumstances might be acceptable.

As a queer-friendly person, I think that society, including health professionals, ought to actively try to change the stigmatising views regarding homosexuality. One way of doing so is to discourage gay people from having conversion therapy. Yet, I do not think that

[78] The claim 'only mental disorders may be medically treated on the basis of being mental disorders' is also different from the claim that conditions such as homosexuality have been intentionally misrepresented as mental disorders in order to justify medical treatment i.e. disease-mongering. Disease-mongering is the process of intentionally creating a disorder to generate a market and a profit.

health professionals should entirely denounce conversion therapy. This is because it will take many decades to change a society's attitude towards homosexuality. In the meantime, denying conversion therapy means that gay people continue to suffer, whereas providing conversion therapy may reduce the torment experienced in homophobic societies. As Murray eloquently points out, regarding non-therapeutic cosmetic surgery,

> if an intervention can alleviate suffering—even if that suffering comes about only because of oppressive and unjust social norms—why should not clinicians do what helps their patients?[79] (Murray in Earp *et. al,* 2014, 9).[80]

The second way of showing that a condition such as homosexuality may not be medically treated is to show that these conditions are not disorders, and that only disorders may be medically treated. A consequence of this approach is that it would mean that if a condition (such as homosexuality) is not a mental disorder, then that condition may never be medically treated. As mentioned directly above, it is debatable whether this would be advantageous or not. In addition, a clear disadvantage of this approach is it rules out too many medical treatments, such as providing pain relief to women in labour.

The third way of showing that a condition such as homosexuality may not be medically treated is to show that these conditions are not disorders, and only mental disorders may be medically treated on the basis of being mental disorders i.e. that the rhetoric of mental disorders can only be used to justify the medical treatment of mental disorders. The notion of the 'rhetoric of mental disorder' is based on the claim (discussed in detail in the following chapter) that there is a link between mental disorders and medical

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[79] While Murray's question is rhetorical a potential answer is given in section two of chapter nine. There it is pointed out that attitudes towards homosexuality will never change if health professionals continue to give conversion therapy.

[80] See also Haldeman in Earp *et. al,* 2014, 9 on conversion therapy.
Professor Omer Bonne's position is that even though being gay is not a mental disorder, gay people in homophobic societies suffer terribly due to the conflict with society which causes them to become depressed. Professor Bonne says he would allow conversion therapy to be given to such people, even though he would not have in his early years as a psychiatrist (Bonne in Earp *et. al*., 2014, 8). It is, at least, arguable that in such a situation, Professor Bonn is treating a mental disorder – not homosexuality but depression. Here, mental disorder has not dropped out of the picture – the rhetoric of mental disorder, namely depression, is used to justify medical treatment, namely conversion therapy. The counter-argument is that such a person does not have a mental disorder (Major Depressive Disorder), but is instead in a mismatched environment (see section two of chapter seven on the 'smoke detector' argument). If so, the conversion therapy is not treating a medical disorder, and so it would not be the case that Professor Bonn is justifying conversion therapy using the rhetoric of mental disorder.

treatment. This link means mental disorders may be medically treated i.e. that mental disorders are the sorts of conditions for which medical treatment is appropriate. There are three main advantages of this approach. Firstly, it recognises and utilises the link between mental disorder and medical treatment. In contrast, the first approach (disorders and non-disorders should be medically treated if the standard bioethical criteria are in favour of medical treatment, or if the condition should be medically treated according to VBM) does not utilise this link, and so ends up in the arguably precarious position that a non-disorder such as homosexuality should be medically treated. Secondly, the third approach can maintain that mental disorders may be medically treated while still allowing that either the standard bioethical criteria or VBM determine whether a condition should be medically treated. The third advantage of this approach (only mental disorders may be medically treated on the basis of being mental disorders) is that it does not make the draconian claim that only disorders may be medically treated. In contrast, the second approach (only disorders may be medically treated) does have this heavy-handed outcome. A potential disadvantage of the third approach is that like the first option, it does not entirely rule out the medical treatment of non-disorders. Non-disorders may be medically treated if the rhetoric of disorder is not used to justify the medical treatment, and non-disorders should be medically treated so long as either the standard bioethical criteria or VBM are in favour of medical treatment. However, that this would occur is not clearly a disadvantage of this approach. I tend to agree with Murray and Earp *et. al.* (2014) that it might be acceptable to medically treat homosexuality in very homophobic societies (or if the patient himself or herself is homophobic). Nevertheless, that a condition is not a mental disorder suggests that we need to be especially cautious in maintaining that it would not be necessarily wrong to medically treat that condition.

This third approach (only mental disorders may be medically treated on the basis of being mental disorders) could be applied to masturbation. If an individual wants medical treatment to curb his or her masturbation, then it might be morally acceptable to treat masturbation, but not on the basis of being a mental disorder. (For this to be successful, it must be shown that masturbation is not a mental disorder.) It is debatable whether this third approach should also be applied to being a runaway slave and being a political dissident. On the one hand, it seems reasonable to say that neither of these

conditions should ever be medically treated. On the other hand, if the medical treatment of these conditions is beneficial, minimises harm and is consensual, then it might be that these conditions should be medically treated. The sting of this claim is removed once it is realised that runaway slaves and political dissidents are unlikely to consent to the medical treatment of these conditions, which means it is unlikely that an instance of either of these conditions should be medically treated. Moreover, if neither of these conditions are mental disorders, then they cannot be compulsorily treated under the New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992. This act states that having a mental disorder is a necessary but insufficient requirement of compulsory treatment.

The third approach also fits well with the conclusion of the previous chapter. That is, if the extension of *mental disorder* did not change relative to the society in question, then it could be determined, for once and for all, a) whether a condition is a mental disorder, and b) whether that condition may be medically treated on the basis of being a mental disorder. Adopting the third approach means that two topics need to be considered. The first is whether there is a link between mental disorder and medical treatment. If there is no link between the two, then it does not make sense to say that 'only mental disorders may be medically treated on the basis of being mental disorders'. The link between mental disorder and medical treatment has been alluded to in this chapter as well as the previous chapter. These two chapters have presumed that if a condition is a mental disorder, then it is the sort of condition that may be medically treated. That a link between mental disorder and medical treatment exists is discussed in the following chapter. There it is shown that while there is no exclusive prescriptive link between mental disorder and medical treatment, there is a pragmatic link between the two.

The second theme requiring discussion is the extension of *mental disorder.* To determine whether a condition may be medically treated on the basis of being a mental disorder, it must be determined whether that condition is a mental disorder. Moreover, to safeguard against a condition being medically treated in all societies, that condition must not fall within the extension of mental disorder in any society. The extension of *mental disorder* is considered in chapters five through eight.

Chapter Four – Link between disorder and medical treatment

1. Introduction

The question at stake in this thesis is whether there is some way of showing, for once and for all, that homosexuality is not a mental disorder. The main thrust of the argument about this has yet to come. Before this will be done, the significance of the question needs to be further established. The question is significant because, despite the contemporary confidence in much of the world that homosexuality is not a mental disorder, in some societies, homosexuality has been considered (and in some others is considered) a mental disorder and medically treated on this basis. But what is the relationship between medical treatment and whether a condition is a disorder? The previous chapter considered three ways in which it might be shown that conditions such as homosexuality, drapetomania, masturbation and sluggish schizophrenia should not or may not be medically treated. It concluded that the most fitting approach is to show that homosexuality and so on may not be medically treated because a) they are not mental disorders and b) only mental disorders may be medically treated on the basis of being mental disorders. Adopting this approach means that two topics need to be considered. The first is whether there is a link between mental disorder and medical treatment. The previous two chapters have alluded to such a link, and this chapter establishes its existence. It shows that there is no exclusive prescriptive link between the two. This is because it is not the case that all disorders should be medically treated and nor is it the case that only disorders may be medically treated. Despite this, this chapter shows that there is a pragmatic link i.e. that mental disorders are the sorts of conditions for which medical treatment is appropriate. The second topic requiring discussion is the extension of *mental disorder.* This is considered in chapters five through eight.

This chapter begins by determining what counts as medical treatment. I take medical treatments to be those products and services, both effective and ineffective, that are provided by health professionals in their capacity as health professionals i.e. medical treatments that fall within the Asclepian frame. Sections three and four then show that

while there is no exclusive prescriptive link between medical treatment and mental disorder, there is a pragmatic link between the two.

Before the link between disorder and medical treatment is discussed, two terminological points need to be made. Firstly, this chapter mainly uses the concept *disorder* rather than *mental disorder*.[81] This is because (as discussed in the introduction to the previous chapter) it is wrong to claim that 'only mental disorders may be medically treated' – physical disorders may also be medically treated. Secondly, to refer to the issue of whether there is a prescriptive link between disorder and medical treatment, I ask whether disorders should (i.e. must) be medically treated. To refer to the pragmatic link between disorder and medical treatment, I claim that it is appropriate to medically treat disorders i.e. that the condition may be medically treated.[82]

2. What is medical treatment?

There are multiple ways in which *medical treatment* could be defined. The first is to claim that something is medical treatment only when it is used to treat a disorder (but not any treatment of disorder). That is, that the treatment is aimed at a disorder is a necessary but insufficient condition of medical treatment. The second is to define *medical treatment* as any treatment of a disorder and only treatment of a disorder. On this view, that the treatment is directed at a disorder is both necessary and sufficient for the treatment in question to be medical treatment. The third is to claim that medical treatments are those products and services that are provided by health professionals. This thesis adopts the third approach because it is a better fit with the way *medical treatment* is used in ordinary language.[83]

The first approach (in which *medical treatment* is defined as 'only treatment of disorders') is similar to that taken by Peter Kramer (1993). He claims that Prozac is a medical treatment in cases in which it treats Major Depressive Disorder, but it is not a medical treatment in cases in which it is used as cosmetic psychopharmacology. That is,

[81] This is despite the fact that section four of the previous chapter (only mental disorders may be medically treated on the basis of being mental disorders) was worded entirely using *mental disorder*.
[82] See the introduction of chapter three.
[83] Hansen J also adopted the third approach in New Health New Zealand v. South Taranaki District Council [2014] NZHC 395 at paras 80-83.

Prozac is not a medical treatment in cases in which it is used to treat low mood that does not meet the criteria for Major Depressive Disorder. On Kramer's approach, to determine whether Prozac is a medical treatment (i.e. whether an instance of prescribing Prozac is a medical treatment), it needs to be determined whether it is being used to treat a disorder or a non-disorder. This means that a) the diagnostic criteria of Major Depressive Disorder need to be established, and b) it also needs to be established that Major Depressive Disorder is a disorder. Using Kramer's approach as an example is slightly confusing as Kramer is interested in whether an instance of prescribing Prozac counts as a medical treatment. In contrast, I am interested in whether some treatment, such as prescribing Prozac in general, counts as a medical treatment. Even so, the first problem with defining *medical treatment* in terms of 'only treatments of disorders' is that it requires that the extension of *disorder* is already settled. (Another problem is that is requires that the diagnostic criteria of each disorder have been established. However, this is not the focus of this thesis.)

The second problem with the first approach is that it does not fit with ordinary language. In everyday language, we consider the treatment provided by health professionals for non-disorders to be medical treatment. For example, even though fertility is not ordinarily considered to be a disorder, we ordinarily think of the contraceptive pill and intra-uterine devices (IUDs) as medical treatments. Likewise, having small breasts is not ordinarily considered to be a disorder. As mentioned in section two of chapter two, this is because having small breasts is not related to something 'going wrong'. Yet, in ordinary language, we think of breast augmentation as a medical treatment.[84] Moreover, if *medical treatment* were defined as 'only treatment of a disorder', it follows that if homosexuality were not a disorder, 'homosexuality should not or may not be medically treated' would be a nonsensical claim. It would be impossible to medically treat homosexuality if homosexuality were not a disorder. Once again, this is a far cry from the way *medical treatment* is used in ordinary language.

The second option claims that medical treatment is any and only treatment of a disorder. The second approach is problematic for the reasons outlined above – it requires *disorder* to be defined, it does not fit with ordinary language, and it might lead

[84] Kraupl-Taylor (1976), Kendell (1986), Reznek (1987, 94, 97) and Cooper (2002) define *disorder*, at least in part, as whatever medical professionals treat. To be clear, they do not define *medical treatment* as any treatment of disorder, but partly define *disorder* as anything that is medically treated.

to non-sensical claims. In addition, we do not ordinarily consider everything done by health professionals to be medical treatment. For example, we would not ordinarily count a health professional praying for his or her patient to be medical treatment. In short, there are two reasons I do not define *medical treatment* in terms of 'only treatments of disorders' or 'any treatment of only disorders' – they both require the scope of *disorder* to be pre-determined and do not fit with ordinary language.

The third approach is to define *medical treatment* as those products and services that are provided by health professionals. This approach does not require the extension of *disorder* to be pre-determined because whether a condition is a disorder is irrelevant to whether the treatment is medical treatment. The third approach is also a better fit with ordinary language as, for example, it considers prescribing contraceptives and performing breast augmentations to be medical treatments. In order to be consistent with ordinary language, both effective and ineffective interventions might be medical treatment. If this were not the case, then this would not fit with ordinary language. For example, historical cases of ineffective interventions, from bloodletting to mercury-based interventions, would not be classed as medical treatments.

As mentioned above, we do not ordinarily consider everything done by health professionals, such as praying for a patient, to be medical treatment. For this reason, I define *medical treatment* as the products and services provided by health professionals in their capacity as health professionals. What does it mean to say that something is provided by health professionals in their capacity as health professionals? A good way of thinking about this is to ask whether the treatment falls within the 'Asclepian frame' (see Brody; 1993). Asclepius is the Roman god of medicine, and the rod of Asclepius is the snake-entwined staff which is still used to symbolise medicine. To say that a treatment falls within the Asclepian frame means that the treatment is something that is learnt in medical school (or nursing school, physiotherapy school and so on) or in the professional development or practice of health professionals. For example, praying for a patient does not fall within the frame because it is not something learnt via medical school, professional development or professional practice. Using the Asclepian frame as a guide to determine whether a health professional is working within his or her capacity as a health professional means therapeutic intention is not sufficient for a treatment to count as a medical treatment. The health professional also needs to be exercising the

skill and judgment of a clinician and acting in a way that other members of the profession deem acceptable. I admit that the borders of the Asclepian frame will be fuzzy. For example, does providing relationship advice, even in one's capacity as a health professional, fall within the Asclepian frame? However, the presence of borderline cases does not prevent the Asclepian frame providing a rough notion of what counts as medical treatment.

In summary, the main problems with defining *medical treatment* in terms of 'any and only treatments of disorders' are that it requires the scope of *disorder* to be already determined and it is does not fit with ordinary language. In contrast, defining *medical treatment* as those products and services that are provided by health professionals (in their capacity as health professionals) does not require *disorder* to be pre-defined. Moreover, this approach is a better fit with ordinary language as it can include products such as contraceptives and services such as performing breast augmentations as medical treatments.

2.1 Medical treatment and the four historical case studies

In chapter two, it was presumed that the treatment given in homosexuality, drapetomania, masturbation and sluggish schizophrenia amounts to medical treatment. This section shows that at least some of the treatment of these conditions counts as medical treatment.

Defining *medical treatment* in this way means that conversion therapies (such as shock treatment and pairing homoerotic stimuli with a nausea-inducing medication) might be medical treatments regardless of whether homosexuality is a disorder. Equally, the medical treatments of people with sluggish schizophrenia (institutionalisation and medication), masturbation (e.g. castration), and drapetomania (being whipped) might be medical treatments regardless of the disorder-status of these conditions. Moreover, these treatments might be medical treatments even if they were (or are) ineffective. Instead, to determine whether these treatments are medical, it needs to be established whether they are (or were) the sorts of things done by health professionals in their capacity as health professionals i.e. whether the treatments fall or fell within the Asclepian frame.

Prior to the 1970s, conversion therapy was likely to have been taught in medical school and so on, and so would have fallen under the Asclepian frame. There might be pockets of the current world in which conversion therapy is still taught in medical school i.e. fall under the Asclepian frame. In all these societies, conversion therapy would count as medical treatment. In Soviet Russia, the institutionalisation and medication of those with sluggish schizophrenia would have been the sort of thing learnt in medical school and so on, and so they would have fallen within the Asclepian frame and so counted as medical treatment.[85] It is likely that at least some of the treatments for masturbation, such as castration and passing needles through the genitals into the bladder fell within the Asclepian frame – they were the sorts of things learnt about in medical school and professional practice. On the other hand, some devices to curb masturbation might not have been fitted by a health professional in their capacity as a health professional. Instead, they might have been fitted by a religious leader, a family member or the person themselves. Such devices do not fall within the Asclepian frame and so they do not count as medical treatments, according to the definition I use.

Finally, Cartwright said the treatment was based on "sound physiological principles" (Cartwright, 1851/2004, 37). This suggests that whipping runaway slaves might have fitted within the Asclepian frame, at the time when these treatments were being administered.[86] In addition to being whipped, Cartwright recommended that runaway slaves be given "some kind of hard work in the open air and sunshine" (Cartwright, 1851/2004, 37). As this is not a product or service provided by a health professional in his or her capacity as a health professional, this does not fall within the Asclepian frame and so is not a medical treatment. While the recommendation might be medical treatment, the 'hard work' itself is not a medical treatment. By analogy, while we do not ordinarily think of healthy eating and exercising as medical treatment, advice given by a

[85] Imagine that a Soviet psychiatrist advised a political dissident to change their political views (to align with that of the government). It is debatable whether this would fit within the Asclepian frame. On the one hand, political views are not the sort of thing taught in medical school and so would not fit within the Asclepian frame. On the other hand, as explained in chapter two, Soviet Russians thought that there could be no logical reason for opposing the Soviet regime, and so the political dissidents must be mentally disordered. This suggests that 'disordered' political views might have been the sort of thing taught in Soviet medical schools, and so dissident political views would fall within the Asclepian frame. If correct, this might mean that the treatment of those with dissident political views also fell within the Asclepian frame.

[86] While it is odd to think of whipping people as medical treatment, considering it to be medical treatment does not mean that it was acceptable or effective.

health professional regarding diet and exercise is medical treatment (Harris, 1983, 211).[87] Equally, if the slave-owners carried out the whipping (as opposed to a health professional), then this would not be classed as medical treatment.

The main point to take from this section is that, on the definition defended here, some of the things done to gay people, runaway slaves, people who masturbated, and those with dissident political views, were medical treatments. This does not entail that the conditions treated are or were disorders. Instead, it is intended to reinforce the claim that there is a link between considering a condition to be a disorder and the appropriateness of medical treatment. This link is discussed in detail in the remainder of this chapter.

3. There is no exclusive prescriptive link between mental disorder and medical treatment

This thesis concerns the claim that it is wrong to use medical treatment to attempt to cure homosexuality. This section, along with the following section, proposes that there is a link between considering something to be a mental disorder and the appropriateness of the medical treatment of that condition. In the following section, I show that it is pragmatic in nature. This pragmatic link is weaker than a prescriptive link. A prescriptive link means that if a condition is a disorder, medical treatment should be offered – offering medical treatment becomes a duty. If this were the case, if homosexuality were a disorder, health professionals would be obliged to medically treat it. Moreover, if there were a prescriptive link, there would be a very strong reason to consider whether it can be demonstrated, for once and for all, that conditions such as homosexuality are not disorders. However, this section shows that there is no exclusive prescriptive link between those conditions that are considered to be disorders and medical treatment. This is because it is not the case that all instances of disorder and only instances of disorder should be medically treated.

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[87] Being in the fresh air sounds similar to the 'Green Prescription' programme in New Zealand in which health professionals give written advice to a patient to be physically active, as part of the patient's health management. The doctor's advice counts as medical treatment, but being physically active is not medical treatment.
Historically, doctors advised their patients to go to a sanatorium in a place with clear air. This is a medical treatment. In contrast, if a doctor advised their patient to move to a warmer climate (but not live in a sanatorium), then this is not medical treatment. More precisely, the doctor's advice counts as medical treatment, but moving to a warmer climate is not medical treatment.

It is clear that not all instances of disorder should be medically treated. For example, if the treatment is clearly harmful, then it should not be given. Instead, disorders should only be medically treated if, for example, the standard bioethical criteria (benefit to patient, harm-minimisation and consent) or Fulford's (2004a) values-based medicine is in favour of medical treatment. Hence, there is no prescriptive link between disorder and medical treatment.[88] We can now turn to the second reason why there is no exclusive prescriptive link between disorder and medical treatment, namely, that it is not the case that only disorders may be medically treated. For example, we think doctors might prescribe contraceptives and pain relief during childbirth even though we do not class fertility or childbirth as disorders. This is both a descriptive and prescriptive claim. Doctors do prescribe contraceptives and pain relief and they should prescribe them in certain circumstances. While there might be some people who dispute the prescriptive claim, this is not the focus of this thesis.

In short, the presence of a disorder is neither necessary nor sufficient to show that medical treatment should be given. Hence, while it is the case that some disorders should be medically treated; it is also true that some non-disorders should be medically treated. Even though there is a prescriptive link between some disorders and medically treatment, this link is not exclusive.

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[88] Germund Hesslow argues that there is no prescriptive link between disorder (or, in his words, disease) and medical treatment (Hesslow, 1993, 7-8). He argues that there are some diseases that are not associated with any discomfort or danger to the patient, such as small fibromas, and such diseases should not be medically treated. In addition, Hesslow argues that there is no prescriptive link between disease and a) whether a condition should be covered by medical insurance (see also Brülde, 2010, 21) or b) whether a person should be held responsible for criminal actions (Hesslow, 1993, 8-10). (While Hesslow considers small fibromas to be diseases, it is debatable whether they would be classified as disorders according to Wakefield's (1992) harmful dysfunction analysis. This is because small fibromas might not be harmful.)
While I agree with Hesslow that there is no prescriptive link between disorder (or disease) and medical treatment, I have a different justification than Hesslow. Hesslow says there is no prescriptive link because not all diseases are associated with discomfort or danger. In contrast, I claim that there is no prescriptive link because mental disorders should only be medically treated if the standard bioethical criteria (benefit to patient, harm-minimisation and consent) or Fulford's (2004a) values-based medicine is in favour of medical treatment. Hesslow's claim that conditions that do not cause discomfort or danger, such as a small fibroma, should not be medically treated could be interpreted in the following way: a small fibroma does not cause distress or discomfort, therefore medically treating the small fibroma would not benefit the patient. In this sense, Hesslow's account could be interpreted to align with my claim that disorders should be medically treated if the standard bioethical criteria are in favour of medical treatment.

4. There is a pragmatic link between disorder and medical treatment

The previous section established that the presence of a disorder is neither necessary nor sufficient to make the claim that medical treatment should be given. Despite this, there is something important in the claim that the nature of disorders is such that they should be medically treated. This is endorsed by many others. For example, Caplan says "choosing to call a set of phenomena a disease involves a commitment to medical intervention" (Caplan in Hesslow, 1993, 6-7) and Albert et al. claim that there is an "implicit mandate to eliminate" disorders and symptoms of disorders (Albert et al. in Nordby, 2006, 170). Bolton says, "it has long been apparent that there is a close connection between making a diagnosis of illness or disorder and warranting clinical attention and treatment" (Bolton, 2008, 190). Moreover, both Reznek (1987, 94, 97) and Cooper (2002) define *disease,* in part, in terms of suitability for medical treatment. That is, suitability for medical treatment is a necessary, though insufficient, element required for a condition to be a disease.

As Wakefield's (1992) 'harmful dysfunction analysis' is discussed in detail in chapters six and seven, special consideration needs to be given to how Wakefield perceives the relationship between mental disorder and medical treatment. Wakefield does not think there is an exclusive prescriptive connection between disorder-status (i.e. whether a condition is a disorder or not) and medical treatment (Wakefield, 2010, 278; 1999, 374). He says, "Some disorders should not be treated, and some nondisorders should be treated" (Wakefield, 2010, 278).[89] Regarding the medical treatment of non-disorders, he says that prescribing contraception and performing cosmetic surgery fall within the ambit of medicine (Wakefield, 2014, 653, 678) and that normal grief and pain during childbirth should be medically treated in certain situations (Wakefield, 2010, 278). Secondly, he says that there might be reason not to medically treat a disorder. For example, Spitzer and Endicott (1978) claim that masturbation stopped being medically treated when it was no longer thought of as a disorder. Wakefield says that this confuses two issues – disorder-status and the 'call to action' i.e. the moral acceptability of medical treatment (Wakefield, 1993, 162). Wakefield also says that disorder is not a

[89] *C.f.* Wakefield's claim that "anyone diagnosed with a psychiatric disorder needs intervention into the internal workings of their mental mechanisms, whether through psychotherapy or drug treatment" (Wakefield, 2005, 93).

call to treatment because it will have absurd implications when reversed – that if society did not feel obliged to treat that disorder, it would no longer be a disorder (Wakefield, 1993, 162).

This is not to say that Wakefield thinks that disorder-status is entirely irrelevant to the moral acceptability of medical treatment. Instead, he thinks that disorders are negative conditions that justify social concern (Wakefield, 1992, 376), that disorder-status has "implications for treatment decisions" (Wakefield, 2010, 7) and that the disorder-status of a condition is "relevant to, but not identical to, such practical questions as whether or how a condition should be treated" (Wakefield, 2010, 178). This fits with Wakefield's claim that in order to maintain credibility, mental health professionals must simultaneously respect the distinction between disorder and non-disorder while "vigorously exploring" justifiable treatment for non-disorders (Wakefield, 2013, 828).

Wakefield says that the appropriateness of medical treatment is based, in part, on factual considerations i.e. whether the condition is caused by an evolutionary dysfunction. He says that one reason that some people are against using growth hormones to treat non-disordered short children is that such shortness is not caused by an evolutionary dysfunction (Wakefield, 2000, 42). Wakefield also compares rambunctious non-disordered children with children with ADHD. He says without the factual component (i.e. dysfunction), we cannot understand why rambunctious children without ADHD are not equal candidates for drug treatment (Wakefield, 2000, 42). This shows that Wakefield thinks there is some relationship between disorder-status and medical treatment.

Furthermore, Wakefield says that it is problematic to medically treat non-disordered people, but it is "even more problematic to label and treat normal people as disordered when they are not so" (Wakefield, 2005, 93). For example, it would be problematic to say that homosexuality is a mental disorder, and medically treating gay people on the basis that homosexuality is a disorder, if homosexuality is not a disorder. While Wakefield does not explicitly claim that the harmful dysfunction analysis can safeguard against the medical treatment of conditions such as homosexuality, it is reasonable to claim that this is a consequence that Wakefield has in mind. Finally, Wakefield says there are costs to more everyday misclassifications of non-disorders as disorders insofar as this might convince the patient to have medical treatment, rather than

changing the environment or adopting a 'watchful waiting' approach (Wakefield, 2010, 278).

In summary, Wakefield thinks that there is no exclusive prescriptive link between disorder-status and medical treatment. However, he thinks that disorder-status is relevant to, though not determinate of, whether a condition should be medically treated.

Earlier it was mentioned that many authors[90] claim there is a link between mental disorder and medical treatment. I do not interpret any of these authors as claiming that there is an exclusive prescriptive link between whether a condition is a disorder and medical treatment. I interpret these authors as referring to the idea that disorders are the sorts of conditions for which medical treatment is appropriate – even though it is not the case that every instance of disorder should be medically treated, medical treatment is still appropriate for all instances of disorders. To say that the medical treatment of disorders is appropriate is not a prescriptive claim, but a pragmatic claim. A pragmatic claim is not descriptive—it does not simply describe that people generally seek medical treatment to cure or ameliorate disorders. Nor is it a prescriptive claim—it does not claim that all instances of disorders should be medically treated. Instead, it lies somewhere between the two such that it is action-guiding but not action-determining.

The pragmatic link between disorder and medical treatment occurs in all societies. For example, in the developed world, cancer is considered to be a disorder and chemotherapy a medical treatment, so there is a pragmatic link between cancer and chemotherapy. Equally, if some society considers a condition such as homosexuality to be a disorder and a treatment such as conversion therapy a medical treatment, then there is a pragmatic link between homosexuality (a disorder, for that society) and conversion therapy (a medical treatment, for that society). To claim that a pragmatic link between disorder and medical treatment exists in all societies does not mean that the extension of disorder (or medical treatment, for that matter) is the same for all societies. To determine, for once and for all, whether homosexuality is a mental disorder and whether it may be medically treated on this basis, the extension of mental disorder needs to be static between societies. However, the extension of disorder does not need to be static to show that the pragmatic link exists in all societies.

[90] Including Caplan, Albert *et al*., Bolton, Reznek, Cooper – Wakefield can now be added to this list.

It would be beneficial if the extension of *medical treatment* were fixed between societies as this means that it could be determined for once and for all whether conversion therapy, for example, were a medical treatment. If it were not a medical treatment, then regardless of whether homosexuality were a mental disorder, there would be no pragmatic link between homosexuality and conversion therapy – conversion therapy would not be appropriate for homosexuality (on the basis that homosexuality is a mental disorder and conversion therapy is a medical treatment). However, this is not the route that that this thesis takes. It focuses on whether *disorder,* specifically *mental disorder,* has a static extension as opposed to whether *medical treatment* has a static extension. The extension of *medical treatment* is a large issue, and is a topic that ought to be considered, in full, elsewhere.

The remainder of this section considers three ways in which the pragmatic link between disorder and medical treatment (i.e. the claim that medical treatment is appropriate for disorders) could be spelled out. The first way in which it might be shown that there is a pragmatic link between disorder and medical treatment (i.e. that the medical treatment of disorders is appropriate) is that medical treatments are generally designed with disorders in mind. For example, anti-depressants (a medical treatment) are designed to cure or ameliorate Major Depressive Disorder (a mental disorder). There are two problems with explaining the pragmatic link between disorder and medical treatment using the 'design match' approach: it is not the case that all medical treatments are a) designed or b) designed to treat disorders. Regarding the first point, some medical treatments are accidentally discovered rather than designed, such as marijuana and quinine (which is used to treat malaria, but naturally occurs in cinchona trees.) Regarding the second point, some medical treatments are designed to treat non-disorders, such as providing pain relief during childbirth (see sections two and three of this chapter).

The second way in which the notion of 'appropriateness' could be articulated is by claiming that medical treatment is appropriate for disorders, if medical treatment is the effective and most efficient way of curing or ameliorating disorders (or if there is potential that in the future medical treatment will be discovered that either cures or

ameliorates the condition[91]). The main problem with this approach is that medical treatment is always appropriate for disorders, but it is not the case that medical treatment is always the effective and most efficient way of curing or ameliorating disorders. For example, keeping active might be the effective and most efficient way of curing my sore back.[92]

The final way of explaining what is meant by the claim 'it is appropriate to medically treat disorders' is to say that it makes sense to seek medical treatment for a disorder. But why does it make sense to medically treat disorders? The Asclepian Frame can be used to say why it makes sense to medically treat disorders. The notion of the Asclepian frame was introduced in the section two of this chapter. Section two suggested that a treatment is a medical treatment if it falls within the Asclepian frame and that all disorders fall within the Asclepian frame. This section takes the notion of the Asclepian frame a step further and considers whether the pragmatic link between disorder and medical treatment can be conceptualised in terms of the Asclepian frame. That is, it asks whether it is appropriate (i.e. makes sense) to medically treat disorders because disorders and medical treatment both fall within the Asclepian frame.

There are two potential problems with conceptualising the pragmatic link between disorders and medical treatment in terms of the Asclepian frame. The first is that the boundaries of the frame are fuzzy. There are examples of conditions (for example, having marital problems[93]) and treatments (for example, talk therapy) for which it is unclear whether they fall within the Asclepian frame. While the borders of the Asclepian frame might be fuzzy, this does not prevent the frame from providing a rough notion of what counts as a disorder, and what counts as a medical treatment.

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[91] The phrase 'potentially medically treatable' is borrowed from Cooper, who argues that to be a disease, a condition must be 'potentially medically treatable'—there must be "reasonable hope that a medical treatment might become available in the future" (Cooper, 2002, 277-278). For Cooper, this is a necessary but insufficient requirement for a condition to be a disease.

[92] This problem could be overcome by making the definitional claim that keeping active is a medical treatment. However, this would be inconsistent with the way *medical treatment* is used in ordinary language.

[93] Another example is a person who is sad though not clinically depressed. This person is not disordered but has a problem of living, to use Szasz's phrase (Szasz, 1960, 113). It is unclear whether this condition falls within the Asclepian frame. This is separate from the case in which it is unclear whether a person is disordered or whether they have a problem of living. However, in this case, it is also unclear whether that condition falls within the Asclepian frame.

The second potential problem is that conceptualising the Asclepian frame as something that is learnt about in medical school and professional development means that both disorders and non-disorders fall within the frame. In other words, all disorders fall within the Asclepian frame and some non-disorders too. This means that a condition's being a disorder is sufficient but not necessary for it to fall within the Asclepian frame. Hence, there is always a pragmatic link between disorders and medical treatment and there is sometimes a pragmatic link between non-disorders and medical treatment. However, this is not a problem because to establish the pragmatic link, it only needs to be shown that being a disorder is sufficient for a condition to fall within the Asclepian frame. That is, it does not need to be shown that being a disorder is necessary for a condition to fall within the Asclepian frame.

In contrast, conceptualising the pragmatic link between disorder and medical treatment in terms of a design match is problematic because not all medical treatments are designed for disorders i.e. being a disorder is not sufficient to show that the medical treatment used to cure or ameliorate that disorder was designed. Equally, a condition's being a disorder is not sufficient to show that medical treatment is an effective and the most efficient way of treating that disorder – not all disorders are best treated via medical treatment.

In short, while each of the three alternatives help to clarify the existence of a pragmatic link between disorder and medical treatment, the best way of conceptualising the pragmatic link is in terms of the Asclepian frame. Using the Asclepian frame means that disorder is sufficient for the pragmatic link to exist. All disorders fall within the Asclepian frame and so it makes sense to medically treat all disorders – the medical treatment of all disorders is appropriate.

5. Conclusion

This chapter has considered the link between disorders (including both mental disorders and physical disorders) and medical treatment. The chapter began by defining *medical treatments* as those products and services, both effective and ineffective, that are provided by health professionals in their capacity as health professionals i.e. those

treatments that fall within the Asclepian frame.[94] To say that a treatment falls within the Asclepian frame means that the treatment is something that is learnt in medical school (or nursing school, physiotherapy school and so on) or in the professional development or practice of health professionals. This definition of *medical treatment* allows the treatment of both disorders and non-disorders to be considered medical treatment. As such, it is a good fit with ordinary language. Moreover, defining *medical treatment* in this way does not require the meaning of *disorder* to be pre-determined. The chapter then showed that there is no exclusive prescriptive link between disorder and medical treatment. It is not the case that all those conditions we ordinarily call disorders should be medically treated and nor is it the case that only those conditions that we ordinarily call disorders may be treated.

While there is no exclusive prescriptive link between disorder and medical treatment, the chapter showed that there is a pragmatic link between disorder and medical treatment. The pragmatic link between disorder and medical treatment refers to the idea that it is appropriate to medically treat disorders, even though it is not the case that all instances of disorders should be medically treated. It was determined that the pragmatic link is best conceptualised in terms of the Asclepian frame – it is appropriate (i.e. makes sense) to medically treat disorders because both disorders and medical treatments fit within the Asclepian frame. Crucially, this does not mean that all disorders should be medically treated.

Describing the pragmatic link using the Asclepian frame means that the medical treatment of all disorders is appropriate, and the medical treatment of some non-disorders may be appropriate. That the medical treatment of some non-disorders may be appropriate does not jeopardise the existence of a pragmatic link between disorders and medical treatment. To establish that the link exists, all that needs to be shown is that disorder is sufficient for appropriate medical treatment.

Why does the existence of a pragmatic link between disorder and medical treatment matter? This thesis aims to show that only disorders may be medically treated on the basis of being disorders. If this is the case, and if a condition such as homosexuality is not a disorder, then that condition may not be medically treated on the basis of being a

[94] While the borders of the Asclepian frame might be fuzzy, this does not prevent the Asclepian frame providing a rough notion of what counts as medical treatment.

disorder.[95] To use this method to safeguard against the medical treatment of homosexuality in all societies, it needs to be shown that homosexuality is not a mental disorder in any society. In other words, it must be shown that the extension of *mental disorder* is static across all societies and the static extension excludes homosexuality. If a) a pragmatic link between disorder and medical treatment exists in all societies and b) it can be shown that homosexuality is not a mental disorder for all societies, then homosexuality may not be medically treated on the basis of being a mental disorder in any society. The same reasoning applies to any other condition that is not a mental disorder. If being a runaway slave or ADHD is not a mental disorder, and there is a pragmatic link between disorder and medical treatment, then being a runaway slave or having ADHD may not be medically treated on the basis of being a disorder. On the other hand, if the extension of *mental disorder* changes from society to society, then we cannot determine, for once and for all, whether a condition is a mental disorder. Nor can we determine, for once and for all, whether a condition may be medically treated on the basis of being a mental disorder. Instead, we would have to accept, for example, that a society that considers homosexuality to be a mental disorder may medically treat homosexuality on the basis that homosexuality is a mental disorder for that society.

As explained in section 1.1 of chapter one, a potential way of safeguarding against the medical treatment of conditions such as homosexuality is to show that

1. Only mental disorders may be medically treated on the basis of being mental disorders, and
2. These conditions are not mental disorders in any society i.e. that the extension of mental disorder is static between societies and excludes these four conditions.

Now that part one (chapters two, three and four) has established the first criterion, the remainder of this thesis focuses on the second criterion – whether it can be shown that conditions such as homosexuality are not mental disorders in any society. Up until now, I have presumed that homosexuality is not a mental disorder. From this point on, I

[95] The condition may still be medically treated, but the rhetoric of disorder cannot be used to show that the medical treatment of homosexuality is appropriate.

question whether homosexuality is a mental disorder. More precisely, I consider whether it is the case that homosexuality cannot be a mental disorder in any society.[96]

[96] Bingham and Banner (2014) start on the basis that whether homosexuality is a mental disorder is, at least in part, an empirical question, but a closed empirical question. That is, they think that homosexuality is not a mental disorder. In contrast, this thesis starts on the basis that whether homosexuality is a mental disorder is a partly empirical question, but an open question. (Thank you to the New Zealand examiner for pointing this out.)

PART TWO – IS HOMOSEXUALITY A MENTAL DISORDER?

Chapter Five – Conceptual Analysis and Ordinary Language Philosophy

1. Introduction

Chapters two and three introduced the argument that one method of safeguarding against the medical treatment of conditions that we, in the developed world, do not consider to be mental disorders, such as homosexuality, is to show that a) those conditions are not mental disorders, and b) only mental disorders may be medically treated on the basis of being mental disorders. The previous chapter established that there is a pragmatic link between mental disorder and medical treatment. This chapter considers the meaning or meanings of *mental disorder.* Chapters two and three also determined that to safeguard against the medical treatment of conditions such as homosexuality, the extension of *mental disorder* must be static across societies. The first part of this chapter focuses on the meaning (or meanings) of *mental disorder.* The second part of this chapter focuses on whether the extension of *mental disorder* is static across societies.

A leading way of determining the meaning of a concept such as *mental disorder* is to carry out conceptual analysis. Conceptual analysis is the process by which test cases are applied to proposed analyses i.e. meanings. If one and only one proposed analysis parallels our intuitions about the meaning of that concept, then that analysis determines the meaning of the concept in question. The intuitive meaning of a concept is determined by examining the way that concept is used in ordinary language. In ordinary language, *mental disorder* can be used in multiple ways and so can have multiple meanings. To avoid this problem, I pin down the specific sense of *mental disorder* in which I am interested, as the way *mental disorder* is used by health professionals in clinical settings and by informed lay-people in serious situations.

As mentioned in section two of chapter one, at times it is unclear whether a term or a concept is being referred to. For example, when one asks how 'mental disorder' is used in ordinary language, it is unclear whether the term MENTAL DISORDER is being referred to, or the concept *mental disorder.* I am interested in the concept which

underlies the ordinary use of the term. Hence, I use *mental disorder* rather than MENTAL DISORDER.

After outlining the basic tenets of ordinary language philosophy, the chapter then considers the advantages and disadvantages of basing the meaning of *mental disorder* on the way the concept is ordinarily used by health professionals and informed lay-people. As discussed in section three, the advantages are two-fold. Firstly, the meaning of *mental disorder* cannot stray so far from its ordinary use, otherwise the talk is no longer about *mental disorder* (i.e. as it is ordinarily used) but something else i.e. something with a new intension and/or extension. Secondly, it maintains the pragmatic link between mental disorder and medical treatment.

Section 4.1 shows that this sense of *mental disorder* has three necessary and sufficient components: to be a mental disorder, the condition must be a) mental, b) disvalued and c) be caused by a dysfunction. Section 4.2 outlines that a major disadvantage of basing the meaning of *mental disorder* on ordinary language (specifically, the ordinary language of health professionals and informed lay-people) is that the extension of *mental disorder* might change over time and culture. For example, homosexuality cannot be a mental disorder in the developed world because homosexuality is not disvalued. Yet homosexuality might be a mental disorder in a culture in which it is disvalued (if it is also mental and caused by a dysfunction).[97] As there is a pragmatic link between mental disorder and medical treatment, in societies in which homosexuality is a mental disorder, homosexuality may be medically treated on the basis of being a mental disorder.

On the other hand, if the extension of *mental disorder* (as used by health professionals and informed lay-people) were the same across all societies, then it could be determined, for once and for all, whether a condition such as homosexuality is a mental disorder and whether it may be medically treated on the basis of being a mental disorder. Section five considers ways in which it might be shown that the extension of *mental disorder* is static over time and culture. One way of doing so is to show that *mental disorder* refers to or, more loosely picks out, a real category – either a scientifically real category (a natural kind) or a morally real category. Alternately, if

[97] See section two of chapter two. Disvalue is further considered in section 4.1 of this chapter.

dysfunction (being a component of the way *mental disorder* is used in ordinary language) is a natural kind, then part of the extension of *mental disorder* might be static between societies. Finally, section four introduces the idea that the extension of *mental disorder* might be fixed if there are Rawlsian primary goods concerning the value-status of mental states.

2. Conceptual Analysis and Ordinary Language Philosophy

One way of determining the meaning of a concept is to carry out conceptual analysis. Conceptual analysis is the process by which test cases are applied to proposed analyses i.e. meanings.[98] If one and only one proposed analysis parallels our intuitions about the meaning of that concept, then that analysis determines the meaning of the concept in question (Harman in Nordby, 2006, 172; Lemoine, 2013, 310-311; Brülde, 2010, 27). For example, it could be said that *bachelor* means unmarried male – this is a proposed analysis of *bachelor.* We intuitively think of a person such as Brad Pitt or Tom Cruise as a bachelor. Since Brad Pitt and Tom Cruise are unmarried males, they are bachelors, according to the proposed analysis. Here, the test case (that we intuitively call Brad Pitt or Tom Cruise a bachelor) fits with the proposed analysis of *bachelor.* At this stage, there is no conflict between the test case and the proposed analysis and so the analysis is acceptable. However, we do not intuitively think of a five year-old boy as a bachelor, yet a five year-old boy fits within the proposed analysis. That is, a five year-old boy is an unmarried male. Here, there is a conflict between the test case (that we do not intuitively call a five year-old boy a bachelor) and the proposed analysis of *bachelor.* Hence, the proposed analysis is unacceptable. It either needs to be rejected in favour of some other analysis, or the analysis needs to be adapted. Regarding adaptation, we might revise the proposed analysis so that *bachelor* means unmarried, adult male. This adapted analysis excludes the five year-old boy, but includes Brad Pitt and Tom Cruise, and so fits with our intuitions. After considering all proposed analysis of *bachelor,* if one and only one proposed analysis fits our intuitions, then according to conceptual analysis, that proposed analysis is the meaning of *bachelor.*

[98] In addition to test cases (i.e. counter-examples), Lemoine says that conceptual analysis must also consider counter-arguments. However, he acknowledges that most counter-arguments will involve counter-examples (Lemoine, 2013, 313-314).

Many philosophers have carried out a conceptual analysis of *mental disorder* (or related concepts such as *health, disease* or *disorder*). These include many of the main players in the philosophy of medicine, such as Boorse, Wakefield and Nordenfelt (Lemoine, 2013).[99] For example, Wakefield (1992) puts test cases against concepts of *disorder* based on a pure value account, whatever health professionals treat[100], statistical deviance, biological disadvantage and unexpected distress or disability. After concluding that all these approaches conflict with the test cases, he proposes a new analysis of *disorder,* namely, disorders as harmful (evolutionary) dysfunctions. Wakefield thinks that conceptualising *disorder* in this way does not conflict with any test cases i.e. it does not conflict with our intuitions. This is not accepted by everyone. For example, Murphy and Woolfolk claim that dyslexia might not be caused by an evolutionary dysfunction, and so, according to Wakefield's analysis, it cannot be a disorder (Murphy and Woolfolk, 2000a, 276). This conflicts with our intuition that dyslexia is a disorder (see also section one of chapter seven). Dyslexia is an example of a test case that is intuitively a mental disorder but might fall outside Wakefield's proposed analysis. There might also be examples of test cases that are intuitively excluded from being mental disorders, but might fall inside Wakefield's proposed analysis. For example, post-bereavement grief might turn out to be caused by an evolutionary dysfunction. If post-bereavement grief is also harmful, then post-bereavement grief would be considered a mental disorder according to Wakefield's proposed analysis. This would remain despite our intuition that post-bereavement grief is not a mental disorder. In this case, we would either need to a) reject Wakefield's proposed analysis (i.e. that all disorders are caused by harmful dysfunctions) or b) revise Wakefield's account so that the analysis included dyslexia and excluded post-bereavement grief, or c) reject our intuitions that dyslexia is a mental disorder and post-

[99] Worhall and Worhall's examination of the meaning of *disease* is a clear example of conceptual analysis (Worhall and Worhall, 2001, 39-48).

[100] If *disorder* were entirely defined in terms of that which health professionals treat, it would follow that all conditions that health professionals treat are disorders and therefore, health professionals only treat disorders (see also Wakefield, 1992, 377 and Boorse, 1977, 543). For example, since doctors medically treat the problem of unwanted fertility using contraceptives, unwanted fertility would be a disorder. This does not fit with ordinary language—we do not ordinarily call unwanted fertility a disorder. (Cooper claims that an unwanted pregnancy that is the result of the failure of contraceptives might be a disorder even though this is contrary to our intuitions (Cooper, 2005, 36).) An additional problem is that to define *disorder* entirely in terms of that which health professionals treat, then all preventative treatments would treat a disorder, even though the patient does not yet have that disorder.

bereavement grief is not. (These options are discussed again in section two of chapter seven.)

In addition to capturing a common understanding of the meaning of a concept and arriving at a definition of a concept, conceptual analysis aims to give a verdict about grey cases (Nordby, 2006, 173). [101] For example, it is not intuitively clear whether homosexuality is a mental disorder, at least if one looks around at how it is categorised across different times and cultures. Some societies intuitively consider homosexuality to be a mental disorder, but other societies intuitively exclude it. Many of those who carry out the conceptual analysis of *mental disorder* aim to provide a verdict on grey cases. However, whether conceptual analysis can provide such a verdict is a moot point (see, for example, Lemoine, 2013).

What does it mean to say that some condition is intuitively a mental disorder or is intuitively not a mental disorder? There are multiple ways in which we can think about the intuitive extension of a concept.[102] This thesis shall not explore these intricacies. Instead, following Wittgenstein I think of the intuitive extension as being the application of a term in a natural language, such as English or Māori. Given that my parents called our four-legged, barking pet a DOG, as a child I intuitively called (our four-legged, barking pet) DOG. Equally, if the people around us call schizophrenia a MENTAL DISORDER, then we intuitively call schizophrenia a MENTAL DISORDER. Put another way, schizophrenia is ordinarily considered to be a mental disorder, and so schizophrenia is intuitively a mental disorder. [103]

To say that intuition about whether a condition is a mental disorder is related to the way *mental disorder* is used in ordinary language does not explain how a reference such as MENTAL DISORDER got its meaning in the first place. Kripke (1980) and Putnam's (1975) causal theory of reference is an influential theory regarding how references gain meaning. This is not the only theory that concerns how references initially gain

[101] There may also be conditions that are intuitively excluded or included as mental disorders (i.e. clear, uncontroversial cases), but which the proposed analysis fails to classify at all (Lemoine, 2013, 310).
[102] For a detailed account, see, for example, DePaul *et. al.,* 2008.
[103] Murphy and Woolfolk think of the intuitive extension of a concept in a slightly different way. They think of intuition as folk psychology – a set of unscientific theories about the mind (Murphy, 2005, 117). For example, a lay-person (a non-scientist) would consider schizophrenia to be a mental disorder, and so schizophrenia is intuitively a mental disorder. This difference does not impact on the argument of this thesis i.e. whether *mental disorder* has a static extension.

meaning, but I adopt it for two reasons. The first is that it fits well with realist accounts of disorder as it concerns natural kinds, and whether mental disorder (or a component of mental disorder) is a natural kind is discussed at length in chapters seven and eight. Secondly, the causal theory of reference is used by Wakefield in his 'black box essentialism' (Wakefield, 1997; 2001, 36) which is considered in detail in chapters six and seven.

According to Kripke (1980) and Putnam (1975), a reference is initially fixed by an act of 'dubbing' or 'baptising' through which a term becomes a rigid designator for that thing. For example, someone might have initially pointed to the clear, potable stuff in lakes and rivers and referred to that stuff as WATER and so WATER became a rigid designator for water. The reference WATER was then lent to others via communicative exchanges. In other words, the term WATER was borrowed by others to refer to the clear, potable stuff in lakes and rivers. By analogy, according to the causal theory of reference, the reference MENTAL DISORDER was initially fixed by an act of dubbing or baptising – someone pointing to an instance of a mental disorder and saying, 'that is a mental disorder'. MENTAL DISORDER became a rigid designator for mental disorders and was lent to others via communicative exchanges. The causal theory of reference is discussed in more detail in section four of chapter six. This is only a brief explanation of how references initially gain their meaning. We can now return to ordinary language philosophy.

Ordinary language philosophers argue that the meaning (or meanings) of everyday concepts should be determined by examining the way that concept is used in ordinary language i.e. the way that concept is used by ordinary people in ordinary situations. Ordinary language philosophers do not consider the way reality is – they are not concerned with positivistic verifications (see Carnap, 1949). Instead, they are interested in the way or ways concepts are used. They claim that considering the way concepts are used has more descriptive power than trying to verify reality. In addition, ordinary language philosophers are more concerned with the use of a term rather than the way a term is defined (Austin in Fulford, 2001, 81; Brülde, 2010, 27). This is because we can use concepts without having a strict definition of them. That is, if you know how to use a term, then you know its meaning. For example, we can use the concept *bald* without trouble, even though we cannot precisely define when a person is bald – is a person

with 50 hairs on his or her head bald (Nordenfelt, 1997, 17-18)? Likewise, ordinary language philosophers claim that we can use *mental disorder* without having a strict definition thereof. While ordinary language philosophers are not interested in a strict definition of a concept, they are still interested in the meaning of a concept, and they claim that the meaning of a concept should be based on the way that concept is used.

That the meaning of a concept should be based in ordinary language is a key theme of Wittgenstein's (1953) philosophy. In his early work in the *Tractatus* (1921), Wittgenstein was interested in meaning as representation – a representation either of something in the world or inside the mind. In his later work, Wittgenstein changed tack. He argued that "the meaning of a word is its use in the language" (Wittgenstein, 1953, § 43) and "if we had to name anything which is the life of the sign, we should have to say that it was its use" (Wittgenstein, 1960, § 4).[104] For example, ordinary language philosophers claim that the meaning of *water* should be based on the way *water* is ordinarily used i.e. *water* refers to the clear, potable liquid found in lakes and rivers.

Regarding the meaning of *mental disorder,* ordinary language theorists claim that the meaning thereof should not be based on scientific findings about mental states. Instead, ordinary language philosophers think the meaning of *mental disorder* should be determined using a conceptual analysis of the way the concept is used in everyday situations. This is not an attack on science – ordinary language philosophers do not claim that science is unimportant. Instead, they say that philosophy and science are separate disciplines. Science is concerned with uncovering facts, whereas philosophy is concerned with conceptual analysis. Nor does it mean that ordinary language philosophers think that science is irrelevant to the meaning of *mental disorder.* Science might be indirectly relevant to the meaning thereof, insofar as science might influence ordinary language such that the applicable science has become part of ordinary language. For example, that water is H_2O is a scientific discovery, but it is a scientific discovery that has been incorporated into ordinary language. That is, most people know that water is H_2O and use WATER to mean H_2O. As will be shown in the following

[104] Wittgenstein also claims that the meanings of terms are based on the way they are used, not *vice versa* (the way a term is used is not based on the meaning of that term). However, in most cases the use of a term can be equated with the meaning of that term (Baker and Hacker, 2005a, 119; see also Baker and Hacker, 2005, 145-158). Hence, I use 'meaning' and 'use' interchangeably. Despite this, I acknowledge that precisely what Wittgenstein meant by 'meaning' and 'use' and the relationship between the two is a complex issue that cannot be delved into more deeply within the confines of this thesis.

chapter, not everybody agrees that the meaning of *water*[105] should be based on the way it is used in ordinary language. Others, such as Kripke (1980) and Putnam (1975), argue that as *water* refers to a natural kind, the meaning thereof should be based on scientific evidence concerning the necessary and sufficient criteria of all instances of water i.e. the real essence of water, namely, H_2O. Even so, Kripke and Putnam's causal theory of reference means that ordinary language is still related to the meaning of *water* as it provides a starting point from which the real essence of water can be identified.

Another key part of Wittgenstein's philosophy of language is that words and concepts can be used in multiple ways and so a word or a concept might have multiple meanings.[106] That is, words are the instruments of language and they have various uses depending on the way language is used. For example, whether some activity is a game depends on the sense in which *game* is used – scrabble is a board game, but it is not an Olympic game.[107] *Mental disorder* can also be used in different ways within ordinary language and so can have multiple meanings. For example, a scientist's account of *mental disorder* might be quite different from the way a mental health professional, a lawyer or an insurance company uses that concept. Even within the law, there are different concepts of *mental disorder* depending on whether it is to be used to exculpate a person from criminal responsibility or used to force a person to have medical treatment (Woolfolk, 2001). Moreover, *mental disorder* might sometimes be used to express a fact, and at other times it might be used to express a value (see Fulford, 1989, 7, 60-67 on the multiple ways in which *disease* is used).[108] As Wittgenstein says, the functions (i.e. uses) of words are as diverse as the functions of tools found in a toolbox (Wittgenstein, 1953, § 11).

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[105] Given that Kripke is interested in naming (i.e. the way words refer), it is arguable that WATER should be used instead of *water.* As explained in section two of chapter one, this thesis italicises concepts and capitalises terms (i.e. words). However, as I am interested in the concept *water*, I have chosen to italicise it rather than capitalise it.

[106] Not everyone accepts Wittgenstein's claim that ordinary language concepts are open i.e. do not have an essence (Nordenfelt, 1997, 17).

[107] Using the idea that ordinary language concepts such as *game* can be used in multiple ways, Wittgenstein develops his family resemblance account. See section 5.1 of chapter six for more on the family resemblance account.

[108] *Dysfunction* can also be used in multiple ways. For example, we sometimes refer to families as dysfunctional and sometimes refer to mechanisms as dysfunctional. The sense of *dysfunction* in which I am interested is the way that it is ordinarily used by health professionals and informed lay-people to mean 'something gone wrong with the body or mind'.

It could be argued that the way (or ways) scientists, mental health professionals, lawyers and insurance companies use *mental disorder* are technical uses rather than ordinary uses. For example, most countries have some sort of mental health legislation that allows for compulsory medical treatment in certain circumstances. In New Zealand, the relevant piece of legislation is the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act stipulates that for a person to be compulsorily treated, that person must have an abnormality of the mind that either a) poses a serious danger to that person or others, or b) seriously diminishes the person's capacity to take care of himself or herself. In contrast, we do not ordinarily require a person to be a serious danger to themselves or others to call that person MENTALLY DISORDERED. We ordinarily classify depressed people as having a mental disorder even though that depressed person might not be a danger to himself, herself or others. However, the way scientists, mental health professionals, lawyers and insurance companies use *mental disorder* are ordinary uses. This aligns with Wittgenstein's philosophy – to call something an Olympic game is a technical use of *game,* but Wittgenstein still considers Olympic games to be games in his family resemblance account. It also aligns with Fulford's claim that ordinary use is not confined to lay use i.e. ordinary use can include ordinary medical use (Nordenfelt, 2001, 73). In other words, ordinary language philosophy does not make a distinction between ordinary and technical (for example, academic, scientific, slang) uses. A technical use of a concept can be ordinary for a certain group. For example, for botanists, *fruit* refers to plants with internal seed-bearing structures. This use of *fruit* is ordinary for botanists. Moreover, according to ordinary language philosophers, the way botanists ordinarily use *fruit* is not 'more true' or more precise than the way lay-people use *fruit.*[109] The way lay-people use *fruit* is perfectly adequate for lay-use.[110] Hence, the ways in which lawyers, scientists and so on ordinarily use *mental disorder* are part of ordinary language and so it must be accepted that *mental disorder* can be used in multiple ways in ordinary language.

I accept the Wittgensteinian claim that *mental disorder* has multiple meanings. (To be clear, I claim that *mental disorder* has multiple meanings. I am not considering whether

[109] Those who oppose ordinary language philosophy argue that ordinary language obstructs a clear view on reality and that an ideal language would represent reality more precisely than ordinary language (See Parker-Ryan (n.d.).)

[110] See Parker-Ryan (n.d) *c.f.* Hacking who suggests that Wittgenstein was opposed to using a family resemblance account to scientific terms such as SPECIES (Hacking, 1991, 115; 1991a, 150).

concepts, in general, have multiple meanings.) That is, I do not claim that the multiple senses in which *mental disorder* is used can be tied together using necessary and sufficient criteria.[111] That *mental disorder* has multiple meanings is problematic for my purposes, as to complete a thorough conceptual analysis of *mental disorder*, I would need to consider all these uses. Moreover, as will become clear later in the chapter, it is problematic because it means a condition such as homosexuality might be considered to be a mental disorder in one sense but not another. There are two ways in which this problem might be dissolved. The first is to claim that there is a general or broad sense of *mental disorder;* the second is to specify the sense of *mental disorder* in which one is interested. Each of these options are now discussed.

The first option is to claim that there is a general or broad sense of *mental disorder* i.e. that there is something (or some things) that tie all these diverse senses of *mental disorder* together. This option picks up on the idea that even though *mental disorder* might have multiple meanings, it is not an open concept (Nordenfelt, 1997, 17-18). A fire-damaged house is not a mental disorder; nor is a broken arm, or happiness[112] or having no sense of humour. That there might be a general sense of *mental disorder* does not necessarily mean that the general sense of *mental disorder* has an essence; that it can be demarcated using necessary and sufficient criteria. It might be that the general sense of *mental disorder* can be analysed using a non-essentialist approach, such as Wittgenstein's family resemblance account of ordinary language concepts or Rosch's prototype account of classification.[113]

Wittgenstein asks us to try to define *game.* He points out that g*ame* is a broad concept. It includes, for example, sports, make-believe, board games, logic games (crosswords, Sudoku) video games, Olympic games and so on. Wittgenstein says that *game* cannot be defined essentially i.e. in terms of necessary and sufficient elements. Despite this, there are similarities between games. For example, board games and team sports are both played with multiple people. Many (though not all) games are fun. Sports, board games

[111] I do not claim that *mental disorder* is an essentialist concept (demarcated by necessary and sufficient elements) and so only has a single meaning.
[112] *C.f.* Bentall, 1992 and Harris *et. al.,* 1993.
[113] Rosch argues that concepts are not identified using an essence, but are characterised by the best examples i.e. prototypes. For example, a robin is a better example of bird than penguin because robins fly and chirp, but penguins do not (Rosch, 1975). See Sadegh-Zadeh (2008) for the difference between prototype and family resemblance theories.

and video games are usually competitive, while make-believe games are not. Wittgenstein's idea is that rather than *game* having an essence, all games share a network of overlapping and criss-crossing properties (Wittgenstein, 1953, § 66.) If a cluster forms when the properties of games are mapped out, then this cluster could be said to provide the general, over-arching meaning of *game.* By analogy, if a cluster forms when the network of overlapping and criss-crossing properties of *mental disorder* are mapped out, then this could be said to be the general meaning of *mental disorder.* In other words, the property cluster will identify the general meaning of *mental disorder.*

There are two main problems with using the general sense of *mental disorder* to avoid *mental disorder* having multiple meanings. Firstly, this is not how Wittgenstein uses the family resemblance account of ordinary language. Instead, he uses it to show that concepts have multiple meanings. That is, Wittgensteinian's might deny that concepts such as *mental disorder* can have a general, over-arching sense. The second problem is that this general sense of *mental disorder* might be so vague that it is of limited use. By analogy, as *run* has over six hundred meanings, there is either no general sense of *run*, or if there is, it is next to meaningless (Winchester, 2011).[114] If the property cluster of the multiple senses of *run* is too loose or too complex, then it might not be used. If so, then this general sense of *run* would not form part of ordinary language. Equally, if the general sense of *mental disorder* is too loose or complex, then the general sense thereof would not be part of ordinary language, and so would not help to analyse the meaning of *mental disorder.*

The second way of avoiding the problem that *mental disorder* can be used in multiple senses and so can have multiple meanings is to identify one sense of *mental disorder* in which one is interested. Due to the problems for the first option outlined above, this is the approach that I adopt. I am interested in the way health professionals use *mental disorder* in a clinical setting, for example, if a health professional tells me that I have a mental disorder such as major depressive disorder or schizophrenia. I am not interested in the way *mental disorder* is used in a flippant, or perhaps metaphorical, sense. For example, if my friend rants and raves about someone eating her sandwich,

[114] Some of the definitions of *run* are homonyms rather than polysemes. Even so, RUN has plenty of polysemes. (A polyseme is a sense of a word that has contiguous meanings, whereas a homonym is an accidental similarity between words, such as the animal *bear* and the verb *bear*.) See Winchester, 2011.

then I might say she is crazy i.e. that she is acting like a mentally disordered person. This is not the sense of *mental disorder* I am interested in. The way *mental disorder* is used in a clinical setting is distinguished from a purely scientific sense of *mental disorder.* A purely scientific sense of *mental disorder* might be used by pathologists and perhaps neuroscientists. Instead, I am interested in the way health professionals use *mental disorder* in a clinical setting. A pathologist might consider the gourmand lesion to be a mental disorder. (The gourmand lesion is a lesion which causes a person to become appreciative of fine food (Regard and Landis, 1997).) However, a health professional would not consider the gourmand lesion to be a mental disorder. This is likely because, as discussed in section 4.1 of this chapter, being appreciative of fine food is not disvalued. Since it is not disvalued, it is not clinically significant. In short, while the clinical sense of *mental disorder* is value-laden, the scientific sense of *mental disorder* might be value-free. This does not mean that science is unrelated to the clinical sense of *mental disorder.* Section 4.1 of this chapter shows that all mental disorders must be caused by a dysfunction, *dysfunction* being a scientific concept. Chapter seven shows that if *dysfunction* picks out a natural kind, then the scientific evidence used to pick out this natural kind should not be constrained by ordinary language.

Lay people can also use this clinical sense of *mental disorder* i.e. it is not restricted to health professionals. I might tell my friends in a serious, non-flippant (non-metaphorical sense) that I have a mental disorder. By analogy, scientists use *gold* to mean the stuff with the atomic number 79, but lay-people can also use *gold* in this way in certain situations. For example, if I say 'Pyrite (fool's gold) is not gold', I have in mind the stuff with the atomic number 79. That health professionals in clinical settings and informed lay-people in serious situations use *mental disorder* in the same way is an empirical claim based on my intuitions. Research would need to be carried out to determine whether informed lay-people do use *mental disorder* in the same way as health professionals. In the absence of such research, I rely on my intuition. The claim that health professionals and informed lay-people use *mental disorder* in the same way is not a conceptual claim. That is, the main task of this thesis is not to determine what this sense of *mental disorder* (i.e. as used by health professionals and informed lay-people) consists of. Instead, the main task of this thesis is to determine if it is possible for this sense of *mental disorder* (i.e. as used by health professionals and informed lay-people) to be static over time and culture.

The sense of *mental disorder* that I am interested in (the way it is used by health professionals in clinical settings and lay-people in serious situations) is similar to the sense of *mental disorder* in which Wakefield is interested, namely, "an account of disorder as it is used in medicine in general, including the mental health professions" (Wakefield, 2000a, 254). Murphy and Woolfolk critique Wakefield on the basis that he (Wakefield) sometimes slips into providing a conceptual analysis of what "an informed member of the public might mean by *mental disorder*" (Murphy and Woolfolk, 2000a, 272). That is, Murphy and Woolfolk claim that Wakefield wavers between analysing a lay sense of *mental disorder* and the clinical sense thereof. I claim that there is no wavering between the two because the way an informed member of the public uses *mental disorder* (i.e. in a serious sense) is the same as the way in which a health professional uses *mental disorder* in a clinical setting.[115]

I have specified that the sense of *mental disorder* that I am interested in is the way that concept is used by health professionals and informed members of the public. It could be argued that such an approach for determining the meaning of *mental disorder* is circular. In the previous chapter, I argued that there is a pragmatic link between mental disorder and medical treatment. It would be meaningless (i.e. tautologous) to claim that there is a pragmatic link between 'the way *mental disorder* is used by health professionals when determining whether medical treatment might be given' and medical treatment. It is akin to saying that there is a pragmatic link between 'those mental disorders that may be medically treated' and medical treatment. However, this circularity is avoided by specifying that while there is a pragmatic link between the sense of *mental disorder* I am interested in (i.e. as *mental disorder* is used by health professionals and informed members of the public) and medical treatment, the pragmatic link is not necessary or definitional. It just happens to be the case that there is a pragmatic link between this sense of *mental disorder* and medical treatment. It might turn out to be the case that there is an instance of mental disorder that may not be medically treated. If so, then I would argue that we should rethink whether there is always a pragmatic link between this sense of *mental disorder* and medical treatment. I

[115] As discussed in detail in chapter seven, Murphy and Woolfolk go on to claim that Wakefield thinks that the clinical sense of mental disorder should be constrained by folk-theory.

do not argue that the condition in question cannot be a mental disorder because it jeopardises the pragmatic link with medical treatment.

In summary, this chapter considers the meaning of the concept *mental disorder.* This section has begun to carry out a conceptual analysis of *mental disorder.* Conceptual analysis utilises the way a concept is used in ordinary language. Ordinary language philosophers, including Wittgenstein, argue that the meaning of everyday concepts, such as *mental disorder*, should be based on the way that concept is used in everyday situations. Wittgenstein also argues, that in ordinary language, concepts can be used in multiple ways and so might have multiple meanings. I agree that *mental disorder* might have multiple meanings, but have identified the specific sense of *mental disorder* in which I am interested: the way *mental disorder* is used by health professionals in clinical settings (i.e. in their capacity as health professionals) and informed lay-people in a serious, non-flippant (non-metaphorical) sense. Although this sense of *mental disorder* can be informed by science, it can be distinguished from a purely scientific sense thereof. Hence, the sense of *mental disorder* that I am interested in is used in both ordinary language and scientific domains. It is a hybrid of ordinary language and science insofar as it takes both into account. Exactly how this occurs will be examined in chapter seven. In the following two sections, I discuss the advantages and disadvantages of basing the meaning of *mental disorder* on ordinary language.

3. The advantages of basing the meaning of *mental disorder* on ordinary language

There are two related advantages of basing the meaning of *mental disorder* in ordinary language. The first is that it would be used in ordinary conversation i.e. *mental disorder* would be of interest to us. (Nordenfelt, 1995, 8). If the meaning of *mental disorder* were not based in ordinary language whatsoever (i.e. if the way *mental disorder* was used in ordinary language were completely unrelated to the meaning thereof), then *mental disorder* might not be used at all in ordinary settings (Nordenfelt, 1995, 8). If ordinary language were irrelevant to the meaning of *mental disorder,* then *mental disorder* might exclude conditions that we take to be paradigm examples of mental disorders such as severe depression. Likewise, *mental disorder* might include conditions that are clearly not mental disorders, such as being a political dissident or very intelligent. If *mental disorder* excluded severe depression and included being very intelligent and a political dissident, it is plausible that *mental disorder* might fall out of the common vernacular. As

Murphy puts it, if the way *mental disorder* is ordinarily used is irrelevant to the meaning thereof, then the meaning of *mental disorder* might stray so far from the way it is used in ordinary language that we are no longer talking about *mental disorder* but something else i.e. something with a new intension and/or extension (Murphy, 2015, 7). In contrast, the way *mental disorder* is ordinarily used by health professionals and informed lay-people is likely to be of interest to the public and so will not fall out of use.

Even if *mental disorder* (the meaning of which is unrelated to ordinary language) did not fall out of the common vernacular, if *mental disorder* bore little or no relation to the way it is used in ordinary language, then it might not have the same practical ramifications. As explained in chapter four, there is a pragmatic link between the way *mental disorder* is used in ordinary language and medical treatment. This can now be made more precise: there is a pragmatic link between medical treatment and the way that *mental disorder* is used by health professionals and informed lay-people – it is appropriate to medically treat the conditions that fall within this sense of *mental disorder.* This is the second advantage of basing the meaning of *mental disorder* on the way it is ordinarily used by health professionals and informed lay-people i.e. the pragmatic link between mental disorder and medical treatment is retained. In contrast, if the meaning of *mental disorder* were unrelated to its ordinary use, then this pragmatic link might be lost. For example, if *mental disorder* included being a political dissident or very intelligent, and if we do not consider medical treatment to be appropriate for political dissidence or intelligence, then the pragmatic link between mental disorder and medical treatment might dissolve.[116]

In short, the first advantage of basing the meaning of *mental disorder* on ordinary language is that it reflects the way that concept is ordinarily used i.e. it will not stray so far that the talk is no longer about *mental disorder* (i.e. as it is ordinarily used) but something else (Murphy, 2015, 7). In turn, it will be of interest to the public and not fall out of use. Secondly, basing the meaning of *mental disorder* on the way it is ordinarily used by health professionals and informed lay-people maintains the pragmatic link between mental disorder and medical treatment.

[116] Alternately, we could make the definitional claim that these conditions are not mental disorders. However, as mentioned earlier, I do not claim that the link is definitional.

4. The disadvantages of basing the meaning of *mental disorder* on ordinary language

The main disadvantage of basing the meaning of *mental disorder* in ordinary language is that the extension of ordinary language concepts such as *mental disorder* might change over time and culture. I do not consider whether the meaning – the intension – of *mental disorder* changes over time and culture. The intension of *mental disorder* might change, but this is not part of my argument.[117] I will show that the extension of *mental disorder* might change, even if the intension does not. However, as the extension of *mental disorder* is dependent on the intension of *mental disorder,* the intension of *mental disorder* needs to be ascertained. In particular, the intension of the sense of *mental disorder* in which I am interested – the way it is used by health professionals and informed lay-people – must be ascertained. By analogy, if *fruit* is used in its botanical sense (plants with internal seed-bearing structures), then avocados, tomatoes and pumpkins are fruit. That is, if the intension of *fruit* is 'plant with internal seed-bearing structures', then avocados, tomatoes and pumpkins fall within the extension of *fruit.* However, if *fruit* is used in its everyday sense to refer to the stuff that we put in a fruit salad or the stuff in one's fruit bowl, then avocado, tomatoes and pumpkins do not fall within the extension of *fruit.* In other words, if the intension of *fruit* is something along the lines of 'edible, sweet, fleshy plant that is put in fruit salad and found in fruit bowls', then avocado, tomatoes and pumpkins do not fall within the extension of *fruit.*

4.1 How is *mental disorder* used by health professionals and informed lay-people?

This section shows that *mental disorder* (as ordinarily used by health professionals and informed lay-people) can be outlined essentially i.e. using necessary and sufficient elements. Cooper also claims that *mental disorder* is an essentialist concept. She says all mental disorders are a) bad things to have, b) such that we consider the afflicted person to be unlucky, and c) can potentially be medically treated (Cooper, 2005; 2014, 41-42). However, it is unclear whether Cooper is interested in the same sense of *mental disorder* in which I am interested. For this reason, I say that I might not be alone in claiming that this sense of *mental disorder* is essentialist, rather than that I am not alone.

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[117] For example, as the internal examiner suggested, some religious groups may consider *mental disorder* to be something going wrong, not with the mind, but with the soul. Despite this, my focus is the extension of *mental disorder.*

I claim that the intension of *mental disorder* as used by health professionals and informed lay-people has three necessary and sufficient elements:

1. All mental disorders must be mental as opposed to physical.
2. All mental disorders must be disvalued as opposed to valued or value-neutral.[118]
3. All mental disorders must be caused by a dysfunction.

This is a descriptive claim about the way health professionals and informed lay-people use *mental disorder.* It is not a prescriptive or stipulative claim about the way these people should use *mental disorder.*

Let's look at each of the three requirements in more detail. Firstly, ordinarily, mental disorders are conditions of the mind as opposed to physical conditions. For example, health professionals and informed lay-people do not ordinarily call a broken arm a mental disorder. As noted in section two of chapter one, I align myself with the mainstream view that the category mental disorder is a sub-category of the category disorder. (The category disorder includes the sub-sets mental disorder and physical disorder.) This fits with Brülde's claim that an ordinary language account of *mental disorder* must a) be consistent with the fact that we ordinarily regard the category mental disorder as a subset of the category disorder and b) an ordinary language account of *mental disorder* should help to distinguish between mental and physical disorders (Brülde, 2010, 27).

Secondly, valued or value-neutral conditions are not mental disorders. For a health professional or an informed lay-person to consider a condition to be a mental disorder, that condition must be disvalued. For example, being happy[119] or intelligent are not normally considered to be mental disorders by health professionals or informed lay-people. Likewise, showing that a condition such as shyness has a biological basis does not show that it is a mental disorder any more than showing that extroversion has a biological basis demonstrates that it is a mental disorder (Gorenstein in Zachar, 2000, 172).

[118] More precisely, all mental disorders must be disvalued for moral reasons – aesthetic or epistemic disvalue, for example, will not suffice.
[119] *C.f.* Bentall, 1992 and Harris *et. al.,* 1993.

As Wakefield claims, it is an "important truth" regarding the concept *disorder* (and the concept *mental disorder*), that disvalue (or in his words, 'harm') is a necessary component (Wakefield, 1992, 376).[120] That is, if *mental disorder* did not have an evaluative component, then it would not be an accurate description of the way it is used by health professionals and informed lay-people.

(Wakefield claims that whether a condition is harmful is determined by society, as opposed to the affected individual.[121] Wakefield says that "in a literate society, a person who does not value reading still has a dyslexic disorder if incapable of learning to read due to a brain dysfunction; and, in a society valuing reproductive capacity, a sterile individual has a disorder even if he or she does not want children" (Wakefield, 2005, 88). I do not align myself with Wakefield's view that harm is determined by society. I leave it an open question as to whether the condition must be disvalued by the individual or society.)

The theory that *mental disorder* has no evaluative component (which Murphy calls 'simple naturalism') has "few adherents" (Murphy, 2015, 19; see also Murphy, 2005, 116). One adherent is Thomas Szasz (1960) who denies the existence of mental disorders and is an objectivist about physical and mental disorders. As an objectivist, Szasz claims that there is a fact of the matter whether a condition is a disorder. He claims that 'damage to bodily structures' is both necessary and sufficient to demarcate disorders i.e. disvalue is not required to demarcate disorders from non-disorders. It might be thought that the disease naturalist, Christopher Boorse, also thinks that *mental disorder* (i.e. *mental disease*) has no evaluative component. However, I will now show that Boorse agrees that disvalue is a necessary component of the way *mental disorder* is used by health professionals and informed lay-people. Boorse (1975) is a naturalist regarding disease. That is, he claims that all diseases are statistically abnormal dysfunctions and that values are not used to determine whether a condition is a statistically abnormal dysfunction.[122] For example, if the gourmand lesion were a

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[120] This reflects Spitzer's (1981) claim that the intractability of the debate over whether homosexuality is a mental disorder is in part a debate about values (Wakefield, 1992, 386; 1993, 162; 2014, 675).
[121] *C.f.* Edward's interpretation of Wakefield which, respectfully, is wrong (Edwards, 2009, 83).
[122] Whether dysfunction is value-free is a moot point (see for example Engelhardt, 1976, 263-266, Ereshefsky, 2009 and Kingma, 2007). The purported value-freedom of dysfunction is not a debate into which I shall enter. Instead, the point is that Boorse maintains that dysfunction is value-free.
While Wakefield uses an aetiological account of dysfunction, Boorse uses a teleological account thereof – a dysfunction occurs if it reduces the likelihood of the goals of survival or reproduction (Boorse, 1977).

statistically abnormal dysfunction, then it would be a disease. It would be a disease even though having such a lesion is not disvalued. Likewise, on Boorse's approach, a dysfunction must reduce the likelihood of survival or reproduction (Boorse, 1977). Boorse admits that if gay people are less likely to reproduce (Cooper, 2005, 18; 2002, 269), then homosexuality might be a disease on his approach (Boorse, 2014, 691). Boorse recognises that most people do not ordinarily classify the gourmand lesion or homosexuality as a disease. However, Boorse is interested in the way *disease* is used by pathologists (Boorse, 1997, 45-46, 49-50; see also 2014, 711-713). He would say that pathologists ordinarily class the gourmand lesion as a dysfunction, and that if homosexuality were a statistically abnormal dysfunction, then pathologists would also classify it as a disease. Boorse says that pathologist's potential classification of homosexuality as a disease "need not be disturbing" because *disease* is a theoretical, as opposed to practical, concept (Boorse, 2014, 691). One implication of this is that Boorse does not think that there is any relationship between classing some condition as a disease and whether that condition merits treatment (Boorse, 1997, 12-13). Importantly, Boorse says that the way *disease* is used by pathologists is different to the way in which it is used by clinicians (i.e. the group that I refer to as 'health professionals and informed lay-people') (Boorse, 1997, 45-46, 49-50; see also 2014, 711-713). Although Boorse claims that the way pathologists use *disease* is value-free, the way pathologists use *disease* is different to the sense of *disease* in which I am interested. I consider *mental disorder* as used by health professionals and informed lay-people, not pathologists.[123] Furthermore, Boorse admits that the way clinicians use *disease* (or as he calls it, *illness* or later, *disease-plus*) is value-laden (Boorse, 1997, 12-13; see also 2014; 684-685). The way clinicians use *disease* (i.e. *illness* or *disease-plus*) is an "ineluctably normative concept" (Boorse, 1997, 12).[124] This means that Boorse would agree with myself (and Wakefield and Cooper) that evaluation is a necessary (but insufficient) component of the way *disease* is ordinarily used by health professionals and informed lay-people. Finally, Boorse says *disease-plus* (i.e. the way *disease* is used by health professionals and informed lay-people) is practical (Boorse, 1997, 11) i.e. there is a link

[123] I consider *mental disorder*, as opposed to *disease* or *mental disease.* However, I take the way health professionals and informed lay-people use *mental disease* to be roughly synonymous with *mental disorder.*

[124] More precisely, Boorse says that therapeutic abnormality is an "ineluctably normative concept" (Boorse, 1997, 12). Therapeutic abnormality is a diagnostic abnormality that merits treatment. A diagnostic abnormality is a clinically apparent pathological state (Boorse, 1997, 12).

between disease-plus and treatment. In a nutshell, Boorse claims that the way pathologists use *disease* is value-free. Even so, Boorse agrees that *disease*-plus is value-laden. I take Boorse's account of *disease-plus* to be the same as the way *disease* is used by health professionals and informed lay-people. If correct, this means that Boorse thinks that the way *disease* (including *mental* disease) is used by health professionals and informed lay-people is value-laden.

The third requirement is that all mental disorders must be caused by a dysfunction. This is based on the fact that not all disvalued conditions are considered to be disorders by health professionals and informed lay-people. Likewise, not all disvalued mental conditions are considered to be mental disorders by health professionals and informed lay-people. The best example of this arises in physical disorder – 'normal' ugliness is disvalued but neither health professionals nor informed lay-people consider it to be a disorder. Regarding mental conditions, neither health professionals nor informed lay-people consider the following conditions to be mental disorders, even though all these ways of being are disvalued: having no sense of humour, lousy taste, a propensity for destructive relationships, chronic rudeness and fascist ideologies (Murphy, 2015, 14; 2005, 119). That not all disvalued mental conditions are considered to be mental disorders shows that the first two elements (that the condition is mental as opposed to physical, and that the condition is disvalued) are insufficient to explain the way *mental disorder* is used by health professionals and informed lay-people. There must be a third element.

As mentioned earlier, Wakefield (1992) says that all mental disorders must be caused by an evolutionary dysfunction. Wakefield would claim that normal ugliness is not a physical disorder because it is not caused by an evolutionary dysfunction. In contrast, ugliness that is caused by elephantiasis is considered to be a disorder because (i.e. on the presumption that) elephantiasis is caused by an evolutionary dysfunction. Regarding mental disorder, we do not consider post-bereavement grief to be a mental disorder. Wakefield says this is because post-bereavement grief is not caused by an evolutionary dysfunction (Wakefield, 2012; First and Wakefield, 2013a, 668). Likewise, Wakefield would say that having no sense of humour, lousy taste, a propensity for destructive relationships, chronic rudeness or fascist ideologies are not mental disorders because these conditions are not caused by an evolutionary dysfunction.

Wakefield's claim that all mental disorders must be caused by evolutionary dysfunctions is problematic because there might be conditions that health professionals and informed lay-people consider mental disorders that are not caused by evolutionary dysfunctions. This will be discussed in more detail in chapter seven. Very briefly, Murphy and Woolfolk (2000a) argue that dyslexia might not be caused by a dysfunction (if the ability to read is not functional in the sense that it is selected by evolution, but a spandrel), ADHD might not be caused by a dysfunction (if it is caused by an environmental mismatch) and anti-social personality disorder might not be caused by a dysfunction (if is caused by 'bad input'). If Murphy and Woolfolk are right that there are conditions that we ordinarily consider mental disorders, but are not caused by evolutionary dysfunctions, there are multiple options. We might reject Wakefield's harmful dysfunction analysis, or we might accept Wakefield's analysis, and argue that these conditions (dyslexia, ADHD, anti-social personality disorder) are not mental disorders. While either of these options could be taken, I accept the second option. My reason for taking the second option is purely pragmatic – it allows me to consider the harmful dysfunction analysis in more detail. (More specifically, it allows me to consider whether, if *dysfunction* picks out a natural kind, this will provide an extension of *dysfunction* that is both static over societies and excludes homosexuality.)

Even though, I accept the harmful dysfunction analysis, there are yet more options. These options listed here are considered in detail in chapter seven. Firstly, we might maintain that dyslexia and so on are caused by a dysfunction, and keep searching for the dysfunction involved (I refer to this as option 2a). Option 2b is to adapt the harmful dysfunction analysis, so that rather than claiming that all mental disorders must be caused by a dysfunction, all mental disorders must have the right antecedent cause (Murphy, 2005; 2015). Thirdly, we could accept the harmful dysfunction analysis, including the claim that all mental disorders must be caused by a dysfunction, but claim that whether a condition is caused by a dysfunction is constrained by ordinary language (option 2c). Finally, we could accept the harmful dysfunction analysis, including the claim that all mental disorders must be caused by a dysfunction, but claim that dysfunction-status is not constrained by ordinary language (option 2d). Option 2d means that the extension of *mental disorder* might not map exactly on to the way it is used in ordinary language (i.e. by health professionals and informed lay-people). For

example, dyslexia, ADHD and anti-social personality disorder might not be mental disorders, and homosexuality might be a mental disorder.

I have claimed that the intension of the way health professionals and informed lay-people ordinarily use *mental disorder*: all mental disorders are a) mental, b) disvalued and c) caused by a dysfunction. My intent in providing this essentialist account of the intension of this sense of *mental disorder* is only to give a rough description of this sense of *mental disorder* to give the reader some idea of what I have in mind. The remainder of this section shall explain that a disadvantage of using this intension of *mental disorder* is that the extension thereof might change over time and culture.

4.2 The extension of *mental disorder* might change over time and culture

The intension of *mental disorder* (as ordinarily used by health professionals and informed lay people) is such that all mental disorders are a) mental, b) disvalued and c) caused by a dysfunction. Specifying the intension of *mental disorder* in this way means that the extension of *mental disorder* might change based on whether the condition is a) classed as mental or physical, b) disvalued and/or c) considered to be caused by a dysfunction. That the extension of *mental disorder* might change based on values is the easiest to understand. The extension of *mental disorder* will change between societies if whether a condition is disvalued changes. For example, homosexuality is not disvalued by most people (including health professionals and informed lay-people) in the developed world and so it cannot be a mental disorder. However, there are societies – in both the past and present – in which homosexuality is disvalued.[125] In such societies, homosexuality might be a mental disorder. Hence, based on the intension of *mental disorder* outlined above, homosexuality might be a mental disorder in some societies but not others.

The extension of *mental disorder* (as ordinarily used by health professionals and informed lay-people) might also change based on whether the condition is classified as physical or mental. It might seem obvious whether a condition is physical or mental. For example, a broken arm is clearly a physical condition whereas schizophrenia is clearly a mental condition. However, there are grey cases. For example, it is arguable that visual problems such as blindness are not physical but mental conditions. Moreover, in many

[125] See section 3.1 of chapter two.

Asian countries, the symptoms of depression are somatic (Kleinman, 1982). Both these examples highlight that it is not always clear whether a condition should be classed as mental or physical. If a condition is considered to be mental in one society, but physical in another, then that condition might be a mental disorder in the first society but cannot be a mental disorder in the second.

Finally, the extension of *mental disorder* (as ordinarily used by health professionals and informed lay-people) might change based on whether a society considers the condition to be caused by a dysfunction (*c.f.* whether the condition is, in fact, caused by a dysfunction i.e. presuming there is a fact of the matter). For example, in the developed world, dyslexia is intuitively thought to be caused by a dysfunction, whereas this would not be the case in a pre-literate society.[126] Moral values might also influence whether a condition is considered to be caused by a dysfunction. For example, during Victorian times, the female orgasm was considered to be caused by a dysfunction. This aligns with the prudish sexual climate of the Victorian era. Nowadays the lack of the female orgasm is considered to be caused by a dysfunction (Wakefield, 2000a, 265-266).[127] This aligns with the more sexually liberated climate of the developed world.

The extension of the way *mental disorder* is used in ordinary language (i.e. by health professionals and informed lay-people) might change over time and culture based on a) differing values, b) whether a condition is classed as mental or physical and c) on whether a society considers the condition to be caused by a dysfunction. The changing extension of *mental disorder* is a disadvantage of basing the meaning of *mental disorder* on ordinary language. This is because homosexuality might be a mental disorder in some societies, but not others. In societies in which homosexuality is a mental disorder, it may be medically treated on this basis. The upshot of this is that the medical treatment of homosexuality cannot be safeguarded against using the argument that the ordinary extension of *mental disorder* (as used by health professionals and informed lay-people) excludes homosexuality in all societies. The extension of *mental disorder* would only be true "in a local or limited sense, i.e. relative to a certain culture, paradigm,

[126] For the sake of clarity, I consider whether dyslexia is caused by a dysfunction i.e. something going wrong in the mind. By *dysfunctional,* I do not mean that a person who struggles to read and write will find it difficult to function in everyday life.
[127] While Wakefield uses this example, he says that values do not influence whether a condition is, in fact, caused by a dysfunction (Wakefield, 1992, 385).

conceptual scheme, linguistic community, or the like" (Brülde, 2005, 7) and so we could not say that societies that consider homosexuality to be a mental disorder are wrong. On the other hand, if the extension of *mental disorder* did not change between societies, then it could be determined, for once and for all, whether a condition such as homosexuality is a mental disorder. In turn, it could be determined, for once and for all, whether a condition such as homosexuality may be medically treated on the basis of being a mental disorder. The following section considers ways in which the extension of *mental disorder* might be static over time and cultures.

(It could also be argued that there is a second disadvantage of basing the meaning of *mental disorder* in ordinary language. This would be based on Wittgenstein's claim that ordinary language concepts such as *mental disorder* can be used in multiple ways and so can have multiple meanings.[128] This means that a condition might be a mental disorder in one sense but not another. For example, a condition might be a mental disorder according to health professionals and informed lay-people but not a mental disorder for the purpose receiving medical insurance. I do not consider this to be a disadvantage. At least, it is not a disadvantage for the purposes of safeguarding against medical treatment for conditions such as homosexuality. This is because the pragmatic link between medical treatment and mental disorder is not between medical treatment and the way insurance companies use mental disorder.[129] Instead, the pragmatic link is between mental disorder and the way health professionals and informed lay-people use mental disorder.)

5. Can the extension of *mental disorder* be fixed over time and culture?

The previous two chapters have introduced the argument that if we want to safeguard against homosexuality from being medically treated on the basis that it is a mental disorder, then it needs to be the case that homosexuality is not a mental disorder in any society. The previous section established that the main disadvantage of basing the meaning of *mental disorder* in ordinary language (i.e. as it is ordinarily used by health professionals and informed lay-people) is that the extension of *mental disorder* might

[128] Wittgenstein, 1953, § 11
[129] Admittedly, there may be an indirect pragmatic link insofar as the way insurance companies use mental disorder may be based on the way health professionals use mental disorder.

change over time and culture, and so conditions such as homosexuality might be a mental disorder is some societies but not others.

If *mental disorder* refers to, or more loosely picks out, a real category, then the extension of *mental disorder* might be fixed over time and culture. By real category, I have in mind a set (of instances) that exists and is independent from beliefs, conceptual schemes, linguistic practices and so on. There are two ways in which *mental disorder* might pick out a real category. Firstly, it could be shown that *mental disorder* picks out a scientifically real category in the same way that *water* picks out a scientifically real category i.e. a natural kind. That is, the concept *water* (which exists in our minds i.e. as the constituents of our thoughts) picks out a natural kind. By examining instances of water, it was discovered that all water is H_2O. Scientists might also find that mental disorder is a real category (i.e. a natural kind) by examining instance of mental disorder. Whether *mental disorder* picks out a natural kind is considered in section two of chapters six. Whether a component of *mental disorder,* namely *dysfunction,* picks out a natural kind is considered in chapter seven.

It might be that *mental disorder* does not pick out a natural kind, but that being a dysfunction is a natural kind. If there is a matter of fact regarding whether a condition is caused by a dysfunction, and if all mental disorders must be caused by a dysfunction (*c.f.* considered to be caused by a dysfunction), then whether a condition is caused by a dysfunction will not change between societies. In turn, the extension of *mental disorder* will be partly static. Whether *dysfunction* refers to or picks out a natural kind is discussed in chapters six and seven. Equally, if there is a matter of fact concerning whether a condition is mental or physical (*c.f.* whether a condition is considered to be mental or physical), then nor will this part of the extension of *mental disorder* change between cultures. This is not discussed further because, as established in chapter four, there is a pragmatic link between medical treatment and both mental disorders and physical disorders. Regardless of whether a condition, such as homosexuality, is a physical or mental disorder, it may be medically treated. Hence, the medical treatment of homosexuality cannot be safeguarded against by showing that homosexuality is a physical disorder rather than a mental disorder. The only way to show that homosexuality is not a mental disorder (and so may not be medically treated on this

basis) is to show either that homosexuality is not disvalued or is not caused by a dysfunction.

It will be beneficial to my project if *mental disorder* picked out a natural kind. If so, it could be determined, for once and for all, whether a condition is a mental disorder. This would mean that it could be determined, for once and for all, whether a condition such as homosexuality may be medically treated on the basis of being a mental disorder. If homosexuality, for example, does not fall within the natural kind mental disorder (presuming it exists), then it cannot be medically treated on the basis of being a mental disorder. In this way, the medical treatment of homosexuality would be safeguarded against. It will also be beneficial to my project, although not to the same extent, if *dysfunction* (being a necessary but insufficient component of *mental disorder*) picked out a natural kind. If *dysfunction* did pick out a natural kind, then the extension of *mental disorder* would be static, at least in part, between societies. However, that it will be beneficial to my project if *mental disorder* or *dysfunction* referred to a real category does not mean that either of them are a real category. What I want to be the case is not necessarily the case. This is, in effect, Aucouturier and Demazeux's (2014) critique of naturalism regarding mental disorder. They point out that we cannot presume that mental disorder is a natural kind. If neither *mental disorder* nor *dysfunction* pick out a real category, then there might not be an extension of *mental disorder* that is fixed between societies, even in part.

There are disadvantages to basing the extension of *mental disorder* on the natural kind dysfunction (presuming it exists).[130] The short discussion here only serves to flag these problems. It might be that dysfunction is a natural kind, but that homosexuality (or other conditions that we do not currently consider to be mental disorders) will be included in the natural kind dysfunction (presuming it exists). That is, the way we ordinarily demarcate between conditions that are mental disorders and conditions that are not mental disorders might not map on to natural kinds. These disadvantages will be discussed in detail in the chapters six and seven.

The second way in which *mental disorder* might pick out a real category is if *mental disorder* picks out a morally real category. *Mental disorder* might refer to a morally real

[130] 'Dysfunction' is not italicised because I am not considering the concept *dysfunction*, but dysfunction (i.e. the set of things that are dysfunctional) itself.

category because disvalue is a necessary component of the ordinary use thereof. If it can be shown that it is a moral truth that homosexuality, for example, is not to be disvalued, then this applies to all societies. It would be a moral truth that homosexuality cannot be a mental disorder in any society. If there are moral truths concerning the value-status of all other mental conditions (e.g. happiness, intelligence, dementia, schizophrenia), then *mental disorder* would refer to a morally real category.[131] If *mental disorder* picks out a morally real category, then the extension of *mental disorder* would be static between cultures. It will be beneficial to my project if *mental disorder* picked out a morally real category because it could be determined, for once and for all, whether a condition is a mental disorder. However, as mentioned above, that it will be beneficial to my project if *mental disorder* referred to a real category does not mean that it is a real category i.e. that there are such things as moral truths, or that there are moral truths concerning the extension of *mental disorder.*

Chapter eight notes the epistemological problem for moral realism (i.e. Mackie's (1977) claim that moral truths are ontologically queer). To avoid this problem, chapter eight does not focus on whether there are moral truths concerning mental disorders. Instead, it utilises Rawlsian primary goods to ground evaluative claims – it asks whether there are any primary goods concerning mental states, and if so, whether these primary goods can fix the extension of *mental disorder.*

6. Conclusion

This chapter began by considering the meaning of *mental disorder* using conceptual analysis and ordinary language. Ordinary language philosophers claim that the meaning of a concept such as *mental disorder* should be based on the way or ways that concept is used by everyday people in everyday situations. In ordinary language, *mental disorder* can be used in multiple ways and so might have multiple meanings. The specific sense of *mental disorder* in which I am interested is the way *mental disorder* in used by health professionals in clinical settings and informed lay-people in a serious, non-flippant sense.

[131] If it is a moral truth that a mental condition, such as dementia, is to be disvalued, and that condition is caused by a dysfunction, then that condition is a mental disorder.

There are two advantages of basing the meaning of *mental disorder* in ordinary language. The first is that *mental disorder* will be used and will be of interest to us (Nordenfelt, 1995, 8). On the other hand, if the meaning of *mental disorder* bore no relation to ordinary language, then *mental disorder* might fall out of the common vernacular. Alternately, we might still use *mental disorder*, but the concept might have strayed so far that the talk is no longer of *mental disorder* (as ordinarily used) but something else (Murphy, 2015, 7). That is, the intension and extension of *mental disorder* might change so that the talk is no longer about the same thing as it once was. The second advantage is that basing the meaning of *mental disorder* on the way it is ordinarily used by health professionals and informed lay-people maintains the pragmatic link between mental disorder and medical treatment. In contrast, if the meaning of *mental disorder* were unrelated to its ordinary use, then this pragmatic link might be lost. For example, imagine that *mental disorder* included being gay, a political dissident or very intelligent. As we do not consider medical treatment to be appropriate for homosexuality, political dissidence and intelligence, then there would be no pragmatic link between this extension of *mental disorder* and medical treatment.

While there are advantages to basing the meaning of *mental disorder* on ordinary language (specifically the way it is used by health professionals and informed lay-people), there is a major disadvantage of doing so. The way *mental disorder* is used by health professionals and informed lay-people has three necessary and sufficient components: a mental disorder is a condition that is a) mental as opposed to physical, b) disvalued and c) caused by a dysfunction. This is a descriptive claim. As values change over time and culture, whether a condition is a mental disorder might also change i.e. the extension of *mental disorder* might change. This is problematic because it means that *mental disorder* might not have a static extension. Homosexuality, for example, might be a mental disorder in one society but not another. In turn, homosexuality may be medically treated in societies in which it falls within the extension of *mental disorder*. We cannot safeguard against the medical treatment of conditions such as homosexuality on the basis that homosexuality is not a mental disorder.

Section four introduced ways in which the extension of *mental disorder* might be fixed over time and culture. The first is if *mental disorder* picks out a real category, either a natural kind or a morally real category. In addition, if *dysfunction* (being a component of

mental disorder) picks out a natural kind, then the extension of *mental disorder* might be partly static. Finally, the extension of *mental disorder* might be static if there are Rawlsian primary goods concerning the value-status of mental states. The remainder of this thesis considers these methods. The following chapter shows that *mental disorder* does not pick out a natural kind and considers whether a component of *mental disorder*, namely *dysfunction*, picks out a natural kind. Rather than showing that *dysfunction* picks out a natural kind, chapter seven considers the implications of *dysfunction* picking out a natural kind, specifically, whether it can show that a condition such as homosexuality is not a mental disorder in any society. Chapter seven shows that while revisionist naturalism fixes the extension of the natural kind dysfunction (presuming it exists), homosexuality might be included in the natural kind thereof. While conservative naturalism means that homosexuality will not be included in the natural kind dysfunction (presuming it exists) at least in the developed world, it does not fix the extension of *mental disorder.* Chapter eight explains the difficulty in showing that a moral claim is true. Chapter eight then considers whether there are Rawlsian primary goods concerning the value-status of mental states. It is shown that while there might be such primary goods, in order to be neutral between competing conceptions of the good life, the primary goods are highly unlikely to fix the extension of *mental disorder* between societies.

Chapter Six – Natural Kinds

1. Introduction

The previous chapter suggested that the way *mental disorder* is ordinarily used by health professionals and informed lay-people has three necessary and sufficient elements: all mental disorders must be a) mental as opposed to physical, b) disvalued and c) caused by a dysfunction. That chapter also established that a major problem with basing the meaning of *mental disorder* on ordinary language (i.e. the way *mental disorder* is used by health professionals and informed lay-people) is that the extension of mental disorder might change between societies. Homosexuality, for example, might be a mental disorder in one society but not another. This is problematic because it means that in societies in which homosexuality is ordinarily considered to be a mental disorder, it may be medically treated on the basis of being a mental disorder. In addition, a shift in values or beliefs in societies that do not currently regard homosexuality as a mental disorder might arise, which means that homosexuality might, once more, be seen as a mental disorder and medically treated on this basis. To safeguard homosexuality from being medically treated on the basis that it is a mental disorder, it needs to be shown that a) homosexuality is not a mental disorder and b) that this applies to all societies – the extension of *mental disorder* needs to be static across all societies. A potential way of showing that the extension of *mental disorder* is static is to show that *mental disorder* picks out a real category. There are two ways in which it might be shown that *mental disorder* picks out a real category. The first is to show that mental disorder exists in the world i.e. to show that *mental disorder* picks out a natural kind. The second is to show that *mental disorder* picks out a morally real category. This chapter considers whether *mental disorder*, or a component thereof, picks out a natural kind. The following chapter shows that even if *mental disorder,* or a component thereof, picks out a natural kind, this may not both fix the extension of *mental disorder* and also ensure that conditions such as homosexuality are excluded from the extension thereof.

This chapter is divided into five main sections. The first gives a brief explanation of natural kinds and shows that *mental disorder* (as ordinarily used by health professionals and informed lay-people) cannot refer to or, more loosely, pick out a natural kind. This

is because natural kinds must not have a necessary evaluative component, and as suggested in the previous chapter, disvalue is a necessary (but insufficient) element of the way *mental disorder* is ordinarily used. To be clear, I consider whether *mental disorder* picks out a natural kind. I do not consider whether types of mental disorders, such as *depression* or *schizophrenia,* pick out natural kinds (*c.f.* Cooper, 2005). To use Cooper's analogy, I consider whether *weed* picks out a natural kind as opposed to whether types of weeds, such as *cooch grass*, pick out natural kinds (Cooper, 2005, 46). I do not consider whether types of mental disorders are natural kinds because even if homosexuality picks out a natural kind, this would not show that homosexuality is a mental disorder. In turn, it would not determine whether homosexuality may be medically treated on the basis of being a mental disorder.

The second section introduces the idea that a component of *mental disorder* might refer to or pick out a natural kind. This is the approach taken by Jerome Wakefield (1992) who argues that all mental disorders are harmful mental dysfunctions, and that *dysfunction* (which includes *mental dysfunction*) picks out a natural kind. Not everyone agrees that all mental disorders must be caused by a dysfunction (see section two of the following chapter and section 4.1 of chapter five on spandrels and dyslexia). However, the main focus of the second section of this chapter is to explain, rather than critique, Wakefield's harmful dysfunction analysis.

Wakefield uses Kripke and Putnam's essentialist account of natural kinds and so the third section considers this account of natural kinds in detail. According to Kripke and Putnam's approach, if *dysfunction* picks out a natural kind, then the extension of *dysfunction* is determined using the real essence thereof—those properties that are shared by (i.e. necessary and sufficient for) all instances of dysfunction and that are linked by natural laws.

It could be argued that as *dysfunction* is a complex phenomenon, it cannot refer to or pick out a natural kind. Non-essentialist accounts of natural kinds are more inclusive (i.e. more kinds are natural kinds) than essentialist natural kinds. This is because there are no elements that are necessary to demarcate the kind. Complex phenomena such as *dysfunction* are more likely to be non-essentialist natural kinds than essentialist natural kinds. Section four thus considers a non-essentialist approach account of natural kinds, namely, the family resemblance approach.

Section five briefly considers some of the arguments posed by others in the debate which claim that Wakefield's account of dysfunction is value-laden. The section does not conclude whether dysfunction is value-laden, or whether it is a natural kind. This enables the following chapter to consider the implications of dysfunction being a natural kind i.e. to consider whether the extension of *dysfunction* would be static between societies. If the extension of *dysfunction* were static, then the extension of *mental disorder* would be partly static between societies. (The following chapter shows that even if *dysfunction* picks out a natural kind, the extension thereof might not be static between societies.)

2. *Mental disorder* does not refer to a natural kind

A natural kind is a technical term used by philosophers to refer to the things studied in natural science, such as water[132], electrons and mice (Cooper, 2005, 45). A natural kind is a 'kind' insofar as it refers to a group of similar things as opposed to an instance of something. For example, the natural kind mice (presuming it is a natural kind) does not just refer to that mouse nesting under my house. It refers to the category mice, which includes that mouse nesting under my house, the mice in cages in laboratories[133] and all the other instances of mice in the world. To say the natural kind mice refers to something that exists in the world is different from saying that instances of mice exist in the world.

A natural kind is 'natural' insofar as the kind exists in the world. That is, natural kinds are the naturally existing discrete partitions of nature. Alternately, in slogan form 'natural kinds carve nature at its joints'.[134] Traditionally, natural kinds are thought to have a real essence —they all share some property or group of properties that is both necessary and sufficient to demarcate the kind. For example, all water shares the property of being H_2O. H_2O is the real essence of water, and so *water* picks out a natural kind. Likewise, the real essence of gold is the atomic number 79 – that some stuff has

[132] Weisberg (2006) argues that H_2O is not a natural kind because H_2O has multiple isotopic isomers and therefore, the essence of water must be much more nuanced than H_2O.
[133] Mice in cages in laboratories may have characteristics that have been created by people (i.e. scientists), yet still fall within the natural kind mouse (presuming it exists).
[134] Natural kinds are the naturally existing discrete partitions of nature. A proposed natural kind (i.e. a natural kind that is proposed by people, usually scientists or philosophers) is a natural kind if it turns out to refer to a discrete partition of things in nature. It is the proposed natural kind that successfully – or otherwise – carves nature at her pre-existing joints (or at least do so if there are any pre-existing joints).

the atomic number 79 is both necessary and sufficient to show that that stuff is gold. The properties of natural kinds are linked together via natural laws. For example, being H_2O is linked with other properties of water, such as, that the freezing point is zero degrees Celsius at one atm (atmosphere of pressure) and so on.

As a natural kind is a naturally existing partition of nature, a natural kind must exist in the world independently of human experience and categorisation. 'Weed' is a category that has been created by people to refer to unwanted plants (Cooper, 2005, 45) and the category 'vermin' has been created by people in virtue of the usefulness of grouping disvalued animals together (Murphy, 2015, 5). Both the categories 'weed' and 'vermin' are dependent on human categorisation. Hence, neither weed nor vermin are natural kinds. Another way of saying that a natural kind must be independent of human experience and categorisation is to say that natural kinds cannot have a necessary evaluative component. For the sake of clarity, a natural kind can be valued or disvalued. Gold (the stuff with the atomic number 79) is a natural kind that is valued. However, the evaluative component is not necessary to the category gold. Something is gold if it has the atomic number 79. This applies regardless of whether gold (the stuff with the atomic number 79) is valued nor disvalued. A natural kind must be value-free because values are human creations and so any category that can only be picked out by values is not independent of humans in the way required to be a natural kind.

In short, for a category to be a natural kind it must fulfil two conditions. Firstly, the kind must refer to or pick out the naturally existing discrete partitions of nature. For a kind to be an essentialist natural kind, it must have a real essence (and the real essence must pick out the natural kind in the right way). Secondly, a natural kind must exist independently of human experience and categorisation.

To show that *mental disorder* (as it is ordinarily used by health professionals and informed lay-people) does not pick out a natural kind, it needs to be shown that a) mental disorder does not exist independently of human experience and categorisation because all mental disorders must be disvalued, and/or b) *mental disorder* does not pick out a naturally existing partition of nature for some other reason (i.e. even if it is not the case that all mental disorders must be disvalued, mental disorder does not exist in the real world) . This section takes the first option – *mental disorder* does not pick out a natural kind because it does not exist independently of humans. As shown in section 4.1

of the previous chapter, disvalue is a necessary component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people. Hence, this sense of *mental disorder* cannot refer to or pick out a natural kind. Since this is sufficient to show that this sense of *mental disorder* is not a natural kind, the second option is not discussed.

Wakefield (1992) claims that disvalue (or in his words, 'harm') is a necessary component of *disorder*, and hence he says that *disorder* does not pick out a natural kind. In a similar vein, Cooper argues that all mental disorders are "bad things to have" (Cooper, 2005, 46; see also Cooper, 2005, 23-28), and so concludes that *mental disorder* does not pick out a natural kind. In addition, Lawrie Reznek (1995; 1987) argues that *disease* (which I consider to be analogous with *disorder*) does not pick out a natural kind because it is value-laden. Moreover, as explained in section 4.1 of the previous chapter, Boorse would agree that disvalue is a necessary component of the way *disease* is used by health professionals and informed lay-people (i.e. *disease-plus*). Hence, Boorse would say that the way *disease* is ordinarily used by health professionals and informed lay-people (i.e. *disease-plus*) does not pick out a natural kind. It might be that there are other senses of *mental disorder,* such as that used by pathologists, that are value-free and so these might pick out natural kinds. However, the sense of *mental disorder* that I am interested in – the way it is used by health professionals and informed lay-people – does not pick out a natural kind.

Aucouturier and Demazeux (2014) claim that because *mental disorder* is not a unified object of enquiry in either ordinary language or science (i.e. there is no extension of *mental disorder* that is widely agreed upon), we cannot determine whether *mental disorder* picks out a natural kind (*c.f. mental disorder* does not pick out a natural kind). Aucouturier and Demazeux ought to admit that *mental disorder* has a degree of unity insofar as almost everyone agrees that disvalue is a necessary component of the way *mental disorder* is used by health professionals and informed lay-people.[135] Hence, this sense of *mental disorder* cannot pick out a natural kind. In short, I disagree with the pair's claim that we cannot determine whether *mental disorder* picks out a natural kind.

[135] *C.f.* Szasz, 1960.

Instead, I claim that the way health professionals and informed lay-people use *mental disorder* does not pick out a natural kind.

3. Wakefield's Harmful Dysfunction Analysis

The previous section showed that the way *mental disorder* is ordinarily used by health professionals and informed lay-people cannot pick out a natural kind because disvalue is a necessary component of this sense of *mental disorder.* This is not the end of the road for the argument that natural kinds might provide an extension of *mental disorder* that is static between societies. It might be that a component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people is a natural kind. For example, Wakefield (1992) says that all mental disorders are caused by a harmful mental dysfunction and that dysfunction is a natural kind.[136] If *dysfunction* picks out a natural kind, then whether a condition is caused by a dysfunction might be static between societies. If so, then part of the extension of *mental disorder* would be static between societies.

Alternately, one could argue, *a la* Boorse, that there is another sense of *mental disorder* (such as the sense used by pathologists) that picks out a natural kind. Boorse (1997) says pathologist's sense of *mental disorder* is a component of the clinical sense of *mental disorder* i.e. that all disease-plusses (conditions that fall within the clinical sense of *disease*) must be diseases (conditions that fall within the pathologists' sense of *disease*).[137] Added to this, there is a pragmatic link between the clinical sense of *mental disorder* and medical treatment. Hence, on Boorse's approach, there is an indirect link between the pathologists' sense of *mental disorder* and medical treatment. This remains even though Boorse says the way pathologists use *mental disorder* is value-free – a theoretical rather than a practical concept (Boorse, 1997, 11).

While either Wakefield's or Boorse's approach could be used to consider whether a component of the clinical sense of *mental disorder* (i.e. the way *mental disorder* is ordinarily used by health professionals and informed lay-people) is a natural kind, this chapter (and the following chapter) considers Wakefield's harmful dysfunction analysis.

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[136] Wakefield implies that *dysfunction* picks out a natural kind that includes both mental and physical dysfunctions. That is, he does not say that *mental dysfunction* picks out one natural kind and *physical dysfunction* picks out a separate natural kind.

[137] See section 4.1 of chapter five.

This is because Wakefield explicitly says that dysfunction is a natural kind, whereas Boorse does not say whether his account of *disease* (as used by pathologists) is a natural kind – Boorse's approach is only amenable to natural kind analysis. This section outlines Wakefield's harmful dysfunction analysis.

Wakefield's (1992) Harmful Dysfunction Analysis was briefly introduced in section 4.1 of chapter five – all mental disorders must be caused by harmful mental evolutionary dysfunctions.[138] Wakefield says that all disorders involve something going wrong, and translates this idea into scientific terms: disorders must be caused by evolutionary dysfunctions. By extension, Wakefield says that all mental disorders are caused by evolutionary mental dysfunctions.

According to Wakefield, functions are effects that explain their causes (Wakefield, 1992, 381-383). Cooper gives a clear explanation of Wakefield's position:

> "The function of eyes is to see, and the fact that vision gives the organism a biological advantage resulted, via the workings of natural selection, in humans having eyes" (Cooper, 2002, 267).

In turn, an evolutionary dysfunction is a failure of a mechanism within an organism to perform the function for which it was designed (Wakefield, 2007, 152). For example, as the function of eyes is to see, if some mechanism related to vision fails, then this is a dysfunction. Wakefield says that this (i.e. that some organ or system is not performing the function for which it was naturally selected) is the real essence of dysfunction (Wakefield, 1999a, 471-472; 2000, 36).

Section 4.1 of chapter five also established that Wakefield's interest in the clinical sense of *mental disorder* is roughly analogous to the sense of *mental disorder* in which I am interested, namely, the way *mental disorder* is used by health professionals in clinical settings and informed lay-people in serious situations. The sense of *dysfunction* in which I am interested is the way that it is ordinarily used by health professionals and informed lay-people to mean 'something gone wrong with the body or mind'. In addition, section four of chapter four explained that while Wakefield does not think there is an exclusive prescriptive connection between disorder-status and medical treatment, he still thinks

[138] More precisely, for a condition to be a mental disorder, the harm needs to be caused by a mental dysfunction (Pickering, 1996, 90).

that disorder-status is relevant to, though not determinate of, whether a condition should be medically treated.

Wakefield says that all disorders are significantly harmful (Wakefield, 1992, 375). In contrast, he says not all dysfunctions are harmful, and therefore not all dysfunctions are disorders. Wakefield gives albinism, fused toes and reversal of heart position as examples of dysfunctions that are not harmful (i.e. do not cause harm or, more precisely, significant harm) (Wakefield, 1992, 375). Regard and Landis's (1997) gourmand lesion (a lesion which causes a person to become appreciative of fine food) is another example of a dysfunction that is not harmful. Likewise, there might be a function that causes males to be aggressive. If this function were to break down, then it would be a dysfunction that is not harmful, at least in the developed world. Nor does Wakefield think that all functions are valuable or desirable. For example, the desire to eat sweet and fatty food might be functional, but in an obesogenic environment, such a function would be harmful as it can lead to premature death. If the desire for sweet and fatty food were functional, then it cannot be a disorder despite being disvalued. Wakefield acknowledges that dysfunction-status might alert us to hidden processes that have negative implications, but the reason that the processes are disvalued has nothing to do with dysfunction-status (Wakefield, 1992, 385; see also Wakefield, 2001, 355).[139]

Wakefield takes *mental disorder* to be a hybrid concept – the harm component of *mental disorder* is evaluative, whereas the dysfunction component is descriptive i.e. value-free.[140] Wakefield is a separatist regarding facts and values i.e. he thinks that the two can be separated.[141] While Wakefield says that *mental disorder* is not a natural kind, he says that dysfunction is a natural kind (Wakefield, 1999a, 471-472). Wakefield adopts Kripke and Putnam's essentialist account of natural kinds, which is discussed in the following section.

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[139] See also section six of this chapter.
[140] As Wakefield thinks that *mental disorder* has both evaluative and descriptive components, this makes him a weak normativist regarding these concepts. In contrast, strong normativists think disvalue is both necessary and sufficient for a condition to be a mental disorder (see section two of chapter two).
[141] In contrast, Putnam, a non-separationist, thinks that the fact and value in thick terms is inextricably entangled (Putnam, 2002, 38). See also Megone, 2000 and section six of this chapter.

4. Kripke and Putnam's essentialist natural kinds

Kripke (1980) and Putnam (1975; 1973) develop an essentialist account of natural kinds in which natural kinds share a set of necessary and sufficient properties. In turn, natural kind concepts (i.e. concepts that refer to or pick out natural kinds) can be demarcated using a set of necessary and sufficient conditions, namely, the possession of properties. Kripke and Putnam's essentialist account of natural kinds is discussed for two reasons. Firstly, it is the account of natural kinds that Wakefield uses. Secondly, using Kripke and Putnam's essentialist account of natural kinds should provide a static extension of a concept such as *dysfunction*, providing it is a natural kind. (However, as discussed in the following chapter, the extension of a natural kind concept might drift away from ordinary language.)

Kripke and Putnam say a term is initially fixed by an act of 'dubbing' or 'baptising' which becomes a rigid designator for that thing. There are two ways in which a reference might be initially fixed. The first is to use an ostensive definition i.e. a definition that points out instances of the extension of the concept. For example, someone might have initially pointed to the clear, potable stuff in lakes and rivers and referred to that stuff as WATER and so WATER became a rigid designator for water. Secondly, something can be dubbed or baptised by describing the instances of the kind. For example, water can be described as a clear, potable liquid found in lakes and rivers (see Alexander & Tobin, 2016). The reference WATER was then lent to others via communicative exchanges. In other words, the term WATER was borrowed by others to refer to the clear, potable stuff in lakes and rivers. There is a causal chain from the way we ordinarily use the reference WATER that stretches back to the initial dubbing. Those at the end of the causal chain (*c.f.* the beginning i.e. the baptism) do not need to know what properties of water the baptiser had in mind to use the concept *water* because there is a causal chain that stretches back to the baptism (see Reimer & Michaelson, 2014, 17-19).[142]

Kripke and Putnam's approach can be compared and contrasted with other accounts of reference. For example, Gotlieb Frege and Bertrand Russell both claim that a reference

[142] Kripke adds that we must intend to use the reference of a proper name or natural kind in the same way in which it was passed down the causal chain. This means that even though 'Napoleon' is normally associated with the French general, I can use 'Napoleon' to refer to my pet cat. What matters is whether I intend to use the name according to its rigid designator or not (Reimer & Michaelson, 2014, 17-18).

is associated with descriptive content (see Reimer & Michaelson, 2014, 6). To use the word, a speaker must have descriptive content in his or her mind. For example, to use the term NAPOLEON, the speaker must be able to describe Napoleon – that he was a French general during the French revolution. Frege's theory of meaning is a form of semantic internalism. That is, Frege claims that meaning is entirely inside the head i.e. references refer to the descriptive content associated with that name in the speaker's mind. In contrast, on Mill's theory of reference, a speaker does not need to have any descriptive content. Instead, the meaning of a term is nothing other than its bearer (see Reimer & Michaelson, 2014, 6-7). This makes Mill's theory of reference a form of semantic externalism – meaning is entirely outside the head.

Kripke and Putnam's causal theory of reference offers a middle of the range approach between purely internal and external theories of reference (Zahavi, 2004, 5). On Kripke and Putnam's causal account, the presence of the causal chain means that there is no descriptive content associated with the reference of a proper name or natural kind. That is, a speaker does not have to have any descriptive content in his or her mind to use the reference. For example, when it was discovered that whales are not fish but mammals, we did not claim that there were no whales. Instead, we said that whales are still whales (*whales* is a rigid designator for whales), but that whales are mammals. That the descriptive content of whales changed – we no longer class whales as fish, but as mammals – shows that the descriptive content of whale does not preserve the use of WHALE. Instead, the rigid designator means that whales remain whales even when the descriptive content changes (Wolf, n.d.; see also Reimer & Michaelson, 2014, 38-39). This makes the causal theory of meaning a form of semantic externalism – a reference depends on facts external to the speaker, such as facts concerning the prior use of the term. While Putnam thinks that there are external facts, these facts are not independent of conceptual choices. He says, "what we say about the world reflects our conceptual choices and our interests, but its truth and falsity is not simply determined by our conceptual choices and interests" (Putnam in Zahavi, 2004, 4). Hence, on the causal theory of reference, meanings are partly inside the head and partly outside the head. Meaning is outside the head insofar as it is partly dependent on external factors such as the causal chain. Yet meaning is inside the head insofar as we did not stop referring to whales as WHALES when we found that whales were not fish but whales. That is, we could be wrong about the descriptive content of WHALES, but still successfully refer to

the creatures we intend to refer to. Likewise, Putnam claims that we can be ignorant of the descriptive properties of WATER (i.e. that water is H_2O) and still successfully use the reference WATER. In other words, WATER refers to water regardless of whether the concept is used before or after Lavoisier found that water is H_2O.

The reference-fixing and reference-borrowing of WATER used the ordinary language properties of water – water is the clear, potable stuff in lakes and rivers. In contrast, when demarcating the natural kind water, Kripke and Putnam do not think we use these ordinary language properties. (Ordinary language properties can also be thought of as the nominal essence of a kind (see Reimer & Michaelson, 2014, 17).) Instead, natural kinds are demarcated using their real essence.[143] The 'real essence' is also known as the internal structure or microstructure. As the name suggests, the real essence of a natural kind is a set of necessary and sufficient properties of that kind (that are linked via natural laws.) For example, the real essence of water is H_2O – that some stuff is H_2O is both necessary and sufficient to show that that stuff is water. The causal chain provides an initial reference which can be modified by the real essence. Imagine we found some stuff that we ordinarily refer to as WATER (i.e. some of the clear, potable liquid found in lakes and rivers), and that upon examining that stuff we found that it is not H_2O but xyz.[144] Putnam and Kripke say we would not call this stuff water because it is not H_2O. This shows, they think, that natural kinds are not demarcated using their superficial or ordinary language properties. Instead, natural kinds are demarcated using their real essence. Moreover, if the real essence of water is H_2O, then it is so in all possible worlds (Kripke, 1980, 48). It follows that if the extension of *water* is based on the natural kind (i.e. the real essence), then the extension of *water* will be static between societies – *water* always means H_2O.

That natural kinds are demarcated using their real essence could mean that people who do not know that the essence of water is H_2O cannot successfully use the concept *water.*

[143] This also applies to proper nouns, but this thesis does not concern proper nouns, and so they will not be discussed further.

[144] This is a version of Putnam's (1973; 1975) Twin Earth thought experiment. On Earth, our pre-scientific ordinary language-definition of *water* is along the lines of that potable liquid found in rivers and lakes that looks, tastes and behaves like water. Putnam imagines a world that is exactly the same as Earth except in one respect –the internal structure (i.e. real essence) of the stuff on Twin Earth that we would ordinarily refer to as WATER is not H_2O but xyz. The water on Twin Earth is the same as the water on Earth in all other respects – it is a clear, potable liquid found in lakes and rivers and so on. However, the stuff on Twin Earth is not H_2O. Since the internal structure of the stuff on Twin Earth is not H_2O, the stuff on Twin Earth is not water.

To deal with this problem Putnam introduces the idea of the linguistic division of labour (Putnam, 1973, 705). The linguistic division of labour means that so long as experts (for example, chemists) know that the real essence of water is H_2O, then laypeople do not need to know the real essence of water to be able to use *water*.[145] The division of linguistic labour is successful because Kripke and Putnam's account of natural kinds is not descriptivist. We do not need to know the descriptive properties (i.e. the real essence) of a natural kind to be able to successfully use that term. The previous chapter outlined Wittgenstein's claim that the meaning of words lies in the way in which they are used in ordinary language. It might be argued that Wittgenstein would claim that basing the meaning of *water* on the real essence (i.e. the linguistic division of labour) is an example of language "on holiday" (Wittgenstein, 1953, §38].[146] Wittgenstein claims that in cases in which we use a term in a way that is not ordinary, language has detached itself from ordinary life i.e. it has gone on holiday. However, Wittgenstein says that the way a term is used in scientific settings can be part of ordinary language (Parker-Ryan, n.d). That is, that chemists use *water* to mean H_2O is ordinary for chemists. This suggests that, so long as it is made clear that a scientific discourse is intended, the way chemists use *water* (i.e. as H_2O) is not an example of language 'on holiday'. A second way of disputing the claim that basing the meaning of *water* on ordinary language is an example of language 'on holiday, is to claim that Wittgenstein was not considering scientific terms such as WATER or SPECIES (Hacking, 1991, 115; 1991a, 150). If Hacking is correct, and water does have a real essence, then Wittgenstein would not say that basing the meaning of *water* on the real essence thereof is an example of language 'on holiday'. (In contrast, Wittgenstein would say that language was 'on holiday', if philosophers assumed that a scientific term, such as SPECIES has a real essence, or indeed any essence, on which the meaning of *species* can be based.)

Applied to dysfunction, Putnam and Kripke would say that the reference of DYSFUNCTION was initially fixed by an act of dubbing or baptising via its superficial features (i.e. its nominal essence). In this respect, the intension and extension of *dysfunction* are related to ordinary language. However, Putnam and Kripke would say

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[145] Atran argues that even experts do not fully grasp the full truth of the internal structure of a natural kind (Atran, 1987, 29).

[146] Wittgenstein also uses the metaphor of an idling engine (Wittgenstein, 1953, § 132). This is similar to the metaphor of language 'on holiday' as they both concern the absence of work. Thank you to the internal examiner for pointing me to Wittgenstein's notion of 'language on holiday'.

that if *dysfunction* picks out a natural kind, then the natural kind is demarcated using the internal structure or real essence of dysfunction—those properties that are shared by (i.e. necessary and sufficient for) all instances of dysfunction and that are linked by natural laws. The natural kind dysfunction (presuming it exists) is not demarcated using its superficial, ordinary language features. If *dysfunction* picks out a natural kind, the rigid designator applies regardless of whether the real essence of dysfunction is known. Putnam's division of linguistic labour means that so long as experts know the real essence of dysfunction (presuming it is a natural kind), then laypeople do not need to know the real essence to successfully use the concept *dysfunction.* Laypeople can successfully use the concept *dysfunction* using its ordinary language or superficial properties.

For the purposes of this chapter (and the following chapter), there are three important parts of Kripke and Putnam's essentialist account of natural kinds. The first is that natural kinds have a real essence—a property or set of properties (linked by natural laws) that are shared by all members of the kind. This means that, according to Kripke and Putnam, if *dysfunction* picks out a natural kind, then it will have a real essence. Not everybody agrees that natural kinds must be essentially demarcated. The following section considers a non-essentialist account of natural kinds. Even if *dysfunction* does not pick out an essentialist natural kind, as non-essentialist accounts of natural kinds are broader (i.e. more inclusive) than essentialist accounts of natural kinds, *dysfunction* might pick out a family resemblance natural kind.

The second important point is that the real essence of a natural kind is stable across all societies – the real essence applies in all possible worlds (Kripke, 1980, 48). This means that if *dysfunction* picks an essentialist natural kind, then the extension will be static between societies. If being caused by a dysfunction is a necessary component of the ordinary extension of *mental disorder*, then the extension of *mental disorder* will be partly static between societies. In contrast, as explained in chapter four, a problem with basing the extension of *mental disorder* on the way it is ordinarily used by health professionals and informed lay-people is that the extension might change over time and culture.

In other words, the aim of this thesis is to determine whether the medical treatment of conditions such as homosexuality can be safeguarded against by claiming that

1. Only mental disorders may be medically treated on the basis of being mental disorders, and
2. These conditions are not mental disorders in any society.

For the second criterion to be fulfilled, it must be shown that the extension of mental disorder is

2.1 Static between societies, and
2.2 Excludes conditions such as homosexuality.

Hence, the second important point of Kripke and Putnam's account is that if *dysfunction* picks out an essentialist natural kind, then criterion 2.1 will be, in part, fulfilled.

If *dysfunction* picks out an essentialist natural kind, will it also fulfil criterion 2.2? No. This is the third important point of Kripke and Putnam's essentialist account of natural kinds. That is, on their account, a natural kind can drift from the way it is used in ordinary language. For example, the real essence of the natural kind water is H^2O. If some stuff has all the ordinary language properties of *water* (i.e. it is a clear, potable liquid found in lakes and rivers) but is not H^2O, that stuff would not fall within the extension of the natural kind water but would fall within the extension of the ordinary use of *water.* In the same way, the natural kind dysfunction (presuming it exists) might have a different extension from the way *dysfunction* is ordinarily used.

The following chapter shows that even if *dysfunction* picks out a natural kind it cannot both show that the extension of mental disorder is static between societies and excludes conditions such as homosexuality. Conservative naturalism means that while homosexuality will be excluded from the natural kind dysfunction (presuming it exists) in the developed world, it does not fix the extension of natural kinds between societies – homosexuality might fall within the natural kind dysfunction in other societies (and in turn, may be a mental disorder and medically treated on this basis). In contrast, revisionist naturalism means that the natural kind dysfunction (presuming it is a natural kind) will fix the extension of *mental disorder* between societies, but it cannot guarantee that homosexuality will be excluded from the natural kind dysfunction (presuming it exists).

5. Non-essentialist accounts of natural kinds

Not everyone agrees with Kripke and Putnam's claim that natural kinds must have a real essence i.e. the internal structure of a natural kind must be able to be demarcated in terms of necessary and sufficient components. Non-essentialist accounts of natural kinds are more inclusive (i.e. more kinds are natural kinds) because there are no elements that are necessary to demarcate the kind. This means that even if dysfunction does not have a real essence, *dysfunction* might still pick out a non-essentialist natural kind. Section 5.1 considers a specific account of non-essentialist natural kinds, namely, Cooper's family resemblance account of natural kinds.

The notion of non-essentialist natural kinds was first used to argue that species are natural kinds i.e. a single species, such as *lilium* or *mus musculus*, might be a natural kind. A species does not have a real essence, and so cannot be an essentialist natural kind. Kripke (1980) argues that the morphological features (i.e. the appearance) of a species cannot be the essence of a species because the appearance of a species is neither necessary nor sufficient to demarcate members of that species from non-members.[147] For example, the essence of *tiger* cannot be that tigers are four-legged animals with yellow and black stripes, as this would mean that albino tigers or three-legged tigers are not tigers (Cooper, 2005, 48).

Moreover, Dupré (1981) argues that evolutionary lineage cannot be the essence of a species. Cooper summarises Dupré's argument into three clear points (Cooper, 2005, 48-49). Firstly, we cannot distinguish cats and dogs by saying that 'cats are the offspring of cats, while dogs are the offspring of dogs' because this just moves the problem of distinguishing cats and dogs to the ancestor cats and dogs. Secondly, that members of a species can successfully breed with each other cannot be the essence of a species. This is because some members of a species will be infertile and because species can interbreed with some other species. There is no criterion that can successfully account for both infertile members and breeding between species and so evolutionary lineage cannot be the essence of a species. (Cooper also notes that breeding patterns are useless when it

[147] See also Ziff and Fodor in Atran, 1987, 42. Atran, following Sperber, objects that *tigers*, for example, can be essentially defined: three-legged tigers fall within the extension of *tiger* because we say that 'the tiger was born without one of its legs' i.e. that, tigers, by nature, have four legs. In contrast, we would not say that by nature, tables have four legs (Atran, 1987, 43).

comes to asexual species.) Finally, genetic properties cannot be the essence of species because there is variation within the genes of a species.

Species cannot be demarcated using necessary and sufficient components that are a) linked by natural law and b) all members of the species share. That is, a species does not have a real essence and so cannot be an essentialist natural kind. Despite this, Boyd (1999; 1999a), Millikan (1991), Dupré (1981), Griffiths (1999), Robert Wilson (1999) and Wilson *et al.* (2007) all argue that species might be a natural kind. They think that Kripke and Putnam's essentialist account of natural kinds is too restrictive and that natural kinds might be demarcated using a non-essentialist approach. This means that even if *dysfunction* does not pick out an essentialist natural kind, it might still pick out a non-essentialist natural kind. In contrast, Brülde implicitly rejects the notion of family resemblance natural kinds with his claim that as there are multiple ways of drawing the line between those conditions that are mental disorders and those conditions that are not mental disorders, this shows that *mental disorder* does not pick out a real category (Brülde, 2005, 2).

Non-essentialist accounts of natural kinds include, for example, family resemblance accounts of natural kinds, Boyd's homeostatic property clusters, Roschian prototype approaches. For the sake of clarity, this is not intended to suggest that Boyd's and Rosch's account utilise family resemblances, but that they are non-essentialist. Boyd's account of homeostatic property clusters is an influential account of non-essentialist natural kinds. Murphy, 2005b, 338-341; Weiskopf, 2017; Hassall, 2016, Zachar (2002)[148] and Kendler *et. al.,* 2011 all consider whether types of mental disorders are natural kinds according to Boyd's approach i.e. homeostatic property clusters. Very little has been written on whether mental disorder or mental dysfunction are homeostatic property clusters (*c.f.* D'Amico, 1995). Due to space constraints, I have opted to consider Cooper's (2005) family resemblance account of natural kinds, as Cooper herself applies this account to *mental disorder* (albeit types of mental disorders, as opposed to *mental disorder* itself) whereas Boyd applies his account to species. Despite this, *dysfunction* might pick out a homeostatic property cluster i.e. dysfunction would be a non-essentialist natural kind. If so, then there would be a truth about

[148] Zachar's (2002) account concerns practical kinds as opposed to natural kinds.

whether a condition is caused by a dysfunction, and in this way, the extension of *dysfunction* might be static between societies.

5.1 Cooper's family resemblance account of natural kinds

A family resemblance account of natural kinds might be beneficial for my purposes in the following way: even if *dysfunction* does not pick out an essentialist natural kind, it might pick out a family resemblance natural kind. This is because family resemblance natural kinds are more relaxed than essentialist natural kinds. This section will show that if *dysfunction* does pick out a family resemblance natural kind, then there is a truth about whether a condition is caused by a dysfunction. In turn, if *dysfunction* picks out a family resemblance natural kind, then the extension thereof might be static between societies.

While Cooper (2005) is a realist, she argues that Kripke and Putnam's essentialist account of natural kinds is too restrictive and that natural kinds might be demarcated using a family resemblance approach. Cooper does not apply her family resemblance account of natural kinds to either disorder or mental disorder (or to use Cooper's terms, disease or mental disease), but instead to types of disorders, both mental disorders and physical disorders. For example, she says that *tuberculosis* and *Huntington's chorea* might pick out family resemblance natural kinds (Cooper, 2005, 45-46, 72). By analogy, she says that *weed* does not pick out a natural kind, but that certain types of weeds, such as *daisies* and *stinging nettles,* might pick out natural kinds (Cooper, 2005, 4, 76). That is, Cooper argues that the meta-categories of *disorder* and *weed* do not pick out natural kinds, but that the sub-categories of types of *weeds* and *disorders* might pick out natural kinds. As shown in section one of this chapter, I agree with Cooper that *mental disorder* does not pick out a natural kind. Whereas Cooper considers whether some types of *disorders* pick out natural kinds, I consider whether *dysfunction* picks out a family resemblance natural kind

Wittgenstein's (1953) family resemblance account of concepts was alluded to in chapter five. It is now pertinent to consider the family resemblance account in more detail. The family resemblance account was first used by Wittgenstein to demarcate concepts such as *game.* Wittgenstein's idea is that rather than *game* having an essence, all games share a network of overlapping and criss-crossing properties (Wittgenstein, 1953, § 66). To

reiterate, no property or group of properties is necessary.[149] On the family resemblance approach, if clusters form when properties are mapped out, this cluster might be a family i.e. a kind. The network of criss-crossing properties is similar to the way that people within a family resemble each other. Although not all family members exactly resemble each other, family members will share many similarities. For example, many (though not all) people in my family are short and round with curly hair. The people in my family do not exactly resemble each other. My family cannot be defined essentially i.e. in terms of necessary and sufficient elements. Even so, members of my family share many properties and everyone within my family has at least one of these properties. If the properties height, weight and hair-type are mapped out on three axes, then these properties would cluster, and we could then argue that the individuals who instantiate the properties are members of the same family—the Knox family.

Wittgenstein uses the family resemblance account to analyse the way concepts such as *game* are used in ordinary language. He does not apply the family resemblance approach to natural kinds.[150] Cooper (2005) argues that natural kinds might not have an essence, but might be demarcated using the family resemblance account. Cooper considers whether some types of disorders are family resemblance natural kinds. For example, while not all instances of schizophrenia exactly resemble each other, if all instances of schizophrenia share a network of properties, then *schizophrenia* might pick out a family resemblance natural kind.[151] I consider whether all dysfunctions share a network of properties, and if so whether *dysfunction* picks out a family resemblance natural kind.

How might *dysfunction* (as used by health professionals and informed lay-people) be a family resemblance concept? That is, what might the properties of this sense of *dysfunction* be? Note that, at this point, I am not considering whether this sense of *dysfunction* picks out a family resemblance natural kind, but whether it is a family resemblance concept. One potential property is that the condition negatively impacts on

[149] Some groups of properties may be sufficient. However, no particular group is sufficient - this is a point about necessity.
[150] Hacking argues that Wittgenstein was opposed to using a family resemblance account to scientific terms (Hacking, 1991, 115; 1991a, 150).
[151] See also Zachar, 2002, 223. Zachar does not argue that types of mental disorder (such as schizophrenia) are natural kinds, but practical kinds. Practical kinds lie in between natural kinds and artificial kinds.

the survival or reproduction of an individual.[152] Secondly, it might be that some dysfunctions are a failure of a mechanism within an organism to perform the function for which it was designed i.e. an evolutionary (aetiological) dysfunction.[153] Thirdly, some dysfunctions might involve some sort of incapacity. If I am unable to walk up a flight of stairs, and I can normally do so (and there is no external impediment), then this could be indicative of a dysfunction.[154] As will become clear throughout the remainder of this section, if these properties are determining properties (if they are linked by natural law such that inductive inferences can be made), then this sense of *dysfunction* will a) pick out a family resemblance concept and further b) pick out a family resemblance natural kind. If, when mapped out, these properties (negatively impacting on survival and reproduction, failure of a mechanism to perform the function for which it was designed, an incapacity) form a property cluster (i.e. a network of overlapping and criss-crossing properties), then *dysfunction* might be a family resemblance concept.

(Neither 'negative impact on survival or reproduction', nor 'caused by an evolutionary dysfunction', nor 'incapacity' are likely to be the essence of the natural kind dysfunction (presuming it exists). Regarding the negative impact on survival and reproduction, for example, sickle cell anaemia is arguably a dysfunction that does not reduce survival in malarial environments (see section 3.3 of chapter one). Evolutionary dysfunction might not be the essence because it is arguable that not all conditions that ordinarily fall within *dysfunction* are caused by an evolutionary dysfunction, such as dyslexia, ADHD and anti-social personality disorder (Murphy and Woolfolk, 2000a; see also section 4.1 of chapter five and section two of chapter seven). Finally, incapacity cannot be the essence of the natural kind dysfunction (presuming it exists) because, for example, early stage cancer (i.e. cancer that has not yet caused symptoms) is not incapacitating.)

Cooper's account of family resemblance natural kinds is based on Duprè's (1993, 1981) family resemblance account of natural kinds. Both Cooper and Duprè's accounts of natural kinds are promiscuously real. Their accounts are real insofar as they claim that the property clusters reflect the real world – the property clusters are not mere conventions. Their accounts are promiscuous because "different clusters can … be

[152] This is taken from Boorse's (1997) essentialist account of *disease.*
[153] This is taken from Wakefield's essentialist account of *dysfunction* (Wakefield, 2007, 152).
[154] This is taken from Fulford's (1989) account of *illness.* See McKnight (1998) for a clear explanation of Fulford's account.

generated by restricting our attention to particular dimensions of the map" (Cooper, 2005, 49). Duprè uses the category 'lily' as an example (Duprè, 1981, 74). Biologically speaking, the genus *lilium* has over one hundred species including garlic and onions. In ordinary language, we do not classify onions and garlic as lilies. Additionally, *lilium* excludes many species that we ordinarily class as lilies such as calla lilies. Duprè's point is that common sense and biology furnish us with different ways of categorising lilies, and that each is equally legitimate. Duprè does not think that one property cluster is privileged over any other—that one cluster is 'more true' than another or that there is a hierarchical structure of clusters. Duprè's account of natural kinds is promiscuously real insofar as a single concept can pick out multiple family resemblance natural kinds. *Lilium* might pick out different family resemblance natural kinds depending on whether we are cooks, cottage gardeners, botanists and so on.[155] Duprè's account is realist insofar as he claims that the property clusters reflect the real world – the property clusters are not mere conventions.

(For the sake of clarity, the network of properties is amongst the properties of *lilium* picked out by a group, such as cottage gardeners or botanists. The network of properties is not between the natural kind *lilium* used by different groups, such as cottage gardeners and botanists. That is, the family resemblance approach does not pick out the meta-meaning of *lilium*.)

That a single concept might pick out multiple family resemblance natural kinds is potentially problematic for my purposes. This is because the extension of these family resemblance natural kinds might differ. For example, *lilium* might pick out a family resemblance natural kind for botanists, and the extension of this kind includes onions and garlic but not calla lilies. *Lilium* might pick out a family resemblance natural kind for cottage gardeners, and the extension of this kind might not include onions and garlic, yet include calla lilies (see Duprè, 1981, 74). By analogy, if *dysfunction* picks out multiple family resemblance natural kinds depending on our interests, then the extension of these natural kinds might differ. Homosexuality might be caused by a dysfunction according to one family resemblance natural kind, but not another. In turn,

[155] It is unlikely that Duprè thinks that there are multiple ways in which a natural kind can be demarcated. For example, it is unlikely that Duprè thinks that *lilium* refers to or picks out a single family resemblance natural kind, but that this natural kind can be demarcated in many ways, depending on that in which we are interested.

homosexuality may be a mental disorder (and medically treated on this basis) according to some accounts of the family resemblance natural kind dysfunction, but not a mental disorder according to some other accounts of dysfunction. However, this problem can be avoided by specifying the sense of *dysfunction* in which I am interested, namely, *dysfunction* as used by health professionals and informed lay-people to denote when something has 'gone wrong' with the body or mind.

Cooper's family resemblance account of natural kinds is also promiscuously real. That is, she agrees with Duprè that a) there can be multiple family resemblance natural kinds associated with a single concept, b) family resemblance natural kinds reflect the real world i.e. family resemblance natural kinds are not mere conventions and c) one family resemblance natural kind is not privileged over any other. However, Cooper critiques Duprè's account – or, at least, his early account – on the basis that his account of family resemblance natural kinds is too broad. That is, she thinks that Duprè's earlier account might incorrectly class accidental or artificial kinds as natural kinds.

In his earlier work, Duprè says that clusters of common sense properties might form natural kinds. In his 1993 book, Duprè claims that properties of family resemblance natural kinds must be "economically useful or strikingly noticeable… [or]… of interest for further theoretical reasons" (Duprè, 1993, 113). Cooper claims that such properties are little better than the properties of accidental kinds (Cooper, 2005, 50). Cooper asks us to imagine tins of tomatoes in Mr. Smith's shop that are three months out of date. As the tins are out of date, Mr. Smith stacked those tins in the storeroom and the heavy-handed cleaner knocked over that stack of out-of-dates tins. Because the tins were slightly out of date and dented, a staff member reduced the price to 59p. Cooper says that on Duprè's account of natural kinds, the tins of tomatoes might constitute a family resemblance natural kind because there will be a cluster of properties concerning the out of date tins of tomatoes being stacked out the back, dented and reduced in price (Cooper, 2005, 49-51). On Duprè's approach, *mental disorder* might also pick out a family resemblance natural kind, when it is not, in fact, a family resemblance natural kind. For example, many people with mental disorders might find it difficult to get a job, have poor physical health, have minimal support networks and so on. All these properties are 'economically useful' and 'of interest for theoretical reasons'. That many people with mental illness find it hard to find and keep a job is economically useful, and

the poor physical health and minimal support networks are clearly of interest to social workers, policy makers and so on. On Duprè's approach, if these properties form a cluster, then *mental disorder* might pick out a family resemblance natural kind, even though these properties only show that mental disorder is an accidental kind.

In his later work, Duprè says that the properties of family resemblance natural kinds must provide a basis for scientific theorising i.e. that the properties must serve an investigative or explanatory function (Duprè, 2002; see also Cooper, 2005, 50-51). This restriction means that Duprè's later account of family resemblance natural kinds is less promiscuous than his earlier account. If common sense properties do not provide a basis for scientific theorising, then property clusters formed by common sense properties do not constitute a family resemblance natural kind. That is, Duprè's later account is less promiscuous because there are fewer ways in which a family resemblance natural kind might be demarcated. The tins of tomatoes in Mr. Smith's shop do not provide a basis for scientific theorising, so they will not form a natural kind. However, the properties of mental disorder listed above (unemployment, poor physical health, minimal support networks) might serve an explanatory function, and so these properties might form a property cluster and so *mental disorder* might still pick out a family resemblance natural kind.

Cooper agrees with Duprè's later account – she agrees that the properties of family resemblance natural kinds must provide a basis for scientific reasoning. She refines Duprè's claim so that the properties of family resemblance natural kinds must be linked together via natural laws such that inductive inferences can be made. She refers to such properties as 'determining properties' (Cooper, 2005, 49-51).[156] For example, the property that water is H_2O is lawfully connected to the properties that water boils when it reaches 100 degrees Celsius (at sea level), that it expands when frozen on so on. Regarding family resemblance natural kinds, Cooper says, for example, the properties of rabbits are lawfully connected insofar as we can infer that anything that looks like a

[156] Like others such as Millikan (2000) and Boyd (1999), Cooper thinks determining properties may be internal (for example, gene selection) and external (for example, nutrition) (Cooper, 2005, 51-52). Cooper admits that, it might not be clear whether a property is a determining property. For example, we can make inductive inferences about red things—in standard circumstances, red things appear red to normal observers. Yet, as being 'red' is not lawfully linked to much else, Cooper says 'red things' is a borderline natural kind (Cooper, 2005, 52).

rabbit will have other 'rabbity' features (Cooper, 2005, 50). The tins of tomatoes in Mr. Smith's shop are not a natural kind on Cooper's account, as there are no natural laws linking the fact that Mr. Smith forgot to check the date, the heavy-handed cleaner knocked the tins over and a staff member priced the tomatoes at 59p (Cooper, 2005, 49-50). That is to say, from the fact that I find a can of tomatoes priced at 59p in Mr. Smith's shop, I cannot infer that it will also have been forgotten when it came to date checking time, and subsequently knocked over by a clumsy cleaner. Being out-of-date, dented and on sale are not determining properties. Equally, unemployment, poor physical health and having minimal support networks are not determining properties of mental disorders – they are not linked by natural laws. That is, there is no natural law linking unemployment and poor physical health and minimal support networks. Hence, on Cooper's approach, these properties are not determining properties, and so these properties cannot show that *mental disorder* picks out a natural kind.

In summary, family resemblance accounts of natural kinds are realist accounts, albeit promiscuously so. While Cooper's family resemblance account of natural kinds is promiscuously real, it is less promiscuous than Duprè's account – especially Duprè's earlier account. As Cooper requires the properties of family resemblance natural kinds to be determining properties, accidental kinds (i.e. kinds that are not natural kinds) will not be classed as natural kinds.

As mentioned at the beginning of this section, a family resemblance account of natural kinds might be beneficial for my purposes insofar as *dysfunction* might pick out a family resemblance natural kind, even if it does not pick out an essentialist natural kind. That is, family resemblance natural kinds provide a more relaxed account of natural kinds while also providing a truth about the extension of a natural kind concept (without being so relaxed as to include accidental or artificial kinds). If *dysfunction* picks out a family resemblance natural kind, then there is a truth about whether a condition is caused by a dysfunction, and so the extension of *mental disorder* might be static between societies.

Section eight of the following chapter returns to family resemblance natural kinds. It asks whether, if *dysfunction* picks out a family resemblance natural kind, it will provide an extension of *dysfunction* that is both static between societies (criterion 2.1) and excludes conditions such as homosexuality, masturbation, being a runaway slave and

being a political dissident (criterion 2.2). If it does, then the extension of *mental disorder* will be partly static between societies and so the medical treatment of these conditions can be safeguarded against. (Chapter four has already established that only mental disorders may be medically treated on the basis of being mental disorders.) Section eight of the following chapter concludes that even if *dysfunction* picked out a family resemblance natural kind, it cannot simultaneously fulfil both components of the second criterion.

6. Is dysfunction value-laden?

Section one showed that as disvalue is a necessary component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people, it cannot be a natural kind. This applies to both essentialist and family resemblance accounts of natural kinds. By extension, if *dysfunction* has a necessary value-component, then nor can *dysfunction* pick out a natural kind – neither an essentialist natural kind nor a family resemblance natural kind. This section briefly considers the arguments that disvalue is a necessary component of *dysfunction*, but leaves it an open question whether *dysfunction* is value-free. This allows me to consider the implications of *dysfunction* picking out a natural kind (either essentialist or family resemblance), namely whether it will provide an extension of *dysfunction* that is both static between societies and excludes conditions such as homosexuality i.e. meets both criteria 2.1 and 2.2.

The vast majority of criticism of Wakefield's harmful dysfunction analysis is directed at the purported value-freedom of *dysfunction*. For example, Sadler and Agich argue that in his account of *dysfunction*, Wakefield uses evaluative terms such as 'beneficial' and 'failure', and these terms cannot be translated into purely descriptive terms without loss of meaning (Sadler and Agich, 1995, 224). Wakefield responds that while he sometimes uses evaluative terms, these are not necessary to explain *function* and *dysfunction* (Wakefield, 1995, 234; see also 1992, 385 and 2000a, 265-266). Sadler and Agich (along with Fulford, 1999) also argue that Wakefield's account of *dysfunction* has a teleological element – functions were selected for a purpose and therefore, have an end. As functions are goal-directed and goals are valued, functions must be valued and dysfunctions must be disvalued. Wakefield responds that while his account speaks of goals, purposes and designs, this is "strictly a convenient language for de-scribing [*sic*] these nonintentional causal features of biological mechanisms that happen to be shared

with genuine goals, purposes, and designs" (Wakefield, 1995, 237). Wakefield claims that a dysfunction occurs when "symptoms are not caused … by a normal, proportionate reaction to an unusual environmental stressor" (Wakefield, 1997, 646). However, Murphy and Woolfolk argue that values are required to determine what is 'normal', 'proportionate' and 'unusual' (Murphy and Woolfolk, 2000, 246). Murphy and Woolfolk's position differs from that of Sadler and Agich, as Murphy and Woolfolk do not claim that dysfunction in itself is value-laden, but that determining whether something is a dysfunction will inevitably invite value judgments. That is, by claiming that dysfunctions are failures of mechanisms that have been naturally selected, Wakefield faces an epistemological problem – it is difficult, if not impossible, to determine whether something has been naturally selected for (see also McNally, 2001, 312). Murphy and Woolfolk claim that due to this epistemological problem, the application of dysfunction will invoke values. That is, a condition might be disvalued, which biases scientists to find that it is caused by a dysfunction (Murphy and Woolfolk, 2000, 246). Wakefield acknowledges that to discover whether a condition is caused by a dysfunction is "extraordinarily difficult" (Wakefield, 1992, 383), but points out that the epistemological problem has no direct relationship to determining the extension of a concept. He says, "ease of inquiry is not a good indicator of truth" and that to take an ahistorical account of dysfunction would be akin to "the proverbial drunk looking for his keys under the streetlight because that is where the light is best" (Wakefield, 2001, 349). Moreover, he argues that while *function* might have initially picked out valued functions, *function* is a purely factual concept that has nothing to do with the values that motivated the initial interest in *function* (Wakefield, 2001, 355). He gives an analogy with water – water is generally valued, but *water* is a purely factual concept.

In addition to Sadler and Agich and Murphy and Woolfolk's arguments that dysfunction is evaluative, Megone (2000) argues that facts and values cannot be separated, and so dysfunction is both descriptive and evaluative. Thornton (2000) argues that even if the meaning of *mental disorder* could be captured using only factual criteria, this is because we agree on the underlying values. Finally, DeVito argues that Wakefield's account of dysfunction is evaluative because he has chosen to use an evolutionary account of dysfunction, rather than say a biochemical, anatomical or social account of dysfunction (DeVito, 2000, 553-554).

This is not an exhaustive list of everyone who has argued that Wakefield's *dysfunction* is value-laden.[157] Nor do I make a claim about whether the objections to the value-freedom of *dysfunction* are justified. My point is simply that it is not unanimously accepted that Wakefield's account of *dysfunction* is value-free. If *dysfunction* is not value-free, then it cannot pick out a natural kind. Rather than entering a debate about whether Wakefield's *dysfunction* is value-free, the next chapter considers the implications of *dysfunction* picking out a natural kind. That is, if *dysfunction* picks out a natural kind (either essentialist or family resemblance), then it is arguable that it will provide an extension of *dysfunction* that is static between societies. In turn, part of the extension of *mental disorder* will be static between societies. However, to safeguard against the medical treatment of conditions such as homosexuality, it must also be shown that these conditions do not fall within the natural kind dysfunction (presuming it exists) i.e. that the natural kind dysfunction is co-extensive with the way *dysfunction* is ordinarily used by health professionals and informed lay-people in the developed world. The following chapter considers whether the natural kind dysfunction (presuming it exists) can fulfil both these criteria, and concludes that it cannot.

7. Conclusion

The previous chapter showed that, for my purposes, a major problem with basing the meaning of *mental disorder* on the way in which it is ordinarily used by health professionals and informed lay-people is that the extension of mental disorder might change between societies. This means that homosexuality, for example, may be classed as a mental disorder in some societies, and medically treated on the basis of this classification. In contrast, if *mental disorder* picked out a natural kind (either essentialist or family resemblance), then the extension of *mental disorder* might be static across all societies. However, section one of this chapter showed that the way *mental disorder* is ordinarily used by health professionals and informed lay-people is not a natural kind because a) disvalue is a necessary component of this sense of *mental disorder* and b) natural kinds (both essentialist and family resemblance natural kinds) cannot have a necessary evaluative component.

[157] See, for example, Reznek, 1987.

That *mental disorder* does not pick out a natural kind does not necessarily mean that natural kinds are irrelevant to the extension of *mental disorder*, as a component of *mental disorder* might pick out a natural kind. This aligns with Wakefield's (1992) claim that all mental disorders are caused by harmful mental dysfunctions and that *dysfunction* (which includes mental dysfunctions) picks out a natural kind. Wakefield uses Kripke and Putnam's essentialist account of natural kinds. Kripke and Putnam argue that natural kinds have a real essence—a property or set of properties shared by all members of the kind. The real essence is not made up of superficial (i.e. ordinary language) properties, but reflects the internal structure (i.e. the microstructure) of the natural kind. The real essence of a natural kind concept (i.e. a concept that picks out a natural kind) does not change between societies – it applies in all possible worlds (Kripke, 1980, 48). Hence, if *dysfunction* picks out a natural kind, then both the real essence and extension thereof will be stable between societies. In turn, the extension of *mental disorder* will be, in part, static between societies.

Cooper, and others including Dupré, disagree with Kripke and Putnam's claim that natural kinds must be demarcated essentially. Even if *dysfunction* does not pick out an essentialist natural kind, it might still pick out a non-essentialist natural kind, such as a family resemblance natural kind. This is because non-essentialist accounts of natural kinds are more inclusive (i.e. relaxed – more kinds are natural kinds) than essentialist natural kinds. Family resemblance accounts of natural kinds are promiscuously real – a single concept might pick out multiple natural kinds depending on our interests. Cooper argues that her account will not class accidental kinds as natural kinds. This is because only determining properties can form clusters that represent a family resemblance natural kind. Determining properties are those properties that are linked together via natural laws such that inductive inferences can be made (Cooper, 2005, 49-51).

Rather than concluding whether *dysfunction* picks out a natural kind (either an essentialist natural kind or a family resemblance natural kind), the following chapter considers the implications of *dysfunction* picking out a natural kind. More specifically, it considers whether, if *dysfunction* picks out a natural kind (either an essentialist or family resemblance), this will provide an extension of *dysfunction* that is both static between societies (criterion 2.1) and excludes conditions such as homosexuality (criterion 2.2).

Chapter Seven – Wakefield, Dysfunction and Conservative Naturalism

1. Introduction

Chapter five showed that a problem with basing the meaning of *mental disorder* on the way the concept is ordinarily used by health professionals and informed lay-people is that the extension of *mental disorder* might change over time and culture. This means, for example, that homosexuality might be a mental disorder in one society but not in another. In turn, in societies in which homosexuality is considered to be a mental disorder, it may be medically treated on the basis of being a mental disorder. In contrast, as the real essence of an essentialist natural kind applies in all possible worlds, if *mental disorder* picks out a natural kind, then the extension of *mental disorder* be static over time and culture. If so, it could be determined, for once and for all, whether a condition, such as homosexuality, is a mental disorder.

The previous chapter showed that the way *mental disorder* is used by health professionals and informed lay-people is not a natural kind because disvalue is a necessary component of this sense of *mental disorder.* Despite this, the previous chapter showed that a component of *mental disorder,* namely *dysfunction* might pick out a natural kind (either an essentialist natural kind or a family resemblance natural kind). If being caused by a dysfunction is a necessary component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people, and if *dysfunction* picks out a natural kind, then it is possible that whether a condition falls within that natural kind will not change over time and culture. If so, part of the extension of *mental disorder* would be static – it would not change over time or culture. For example, if homosexuality does not fall in the natural kind dysfunction (presuming it exists), then it cannot be a mental disorder in any time or culture.[158] However, this chapter shows that even if *dysfunction* picks out a natural kind and thereby fixes the extension of *dysfunction,* this may not safeguard against the medical treatment of conditions such as homosexuality (by it allegedly being a mental disorder). This is because conditions such

[158] This line of argument relies on societies recognising that homosexuality does not fall in the natural kind dysfunction (presuming it exists). However, if homosexuality does not fall within the natural kind dysfunction, then societies ought to recognise that homosexuality does not fall in the natural kind thereof.

as homosexuality might fall within the natural kind dysfunction. That is, the natural kind dysfunction (presuming it exists) cannot both provide a static extension of *dysfunction* and ensure that conditions such as homosexuality do not fall within the natural kind dysfunction. The natural kind dysfunction (presuming it exists) can meet either criterion 2.1 or criterion 2.2 but not both.

This is the overall conclusion of this chapter, but a nuance in the claim needs to be considered, namely that there are two kinds of naturalism – conservative naturalism and revisionist naturalism. Conservative naturalists argue that natural kinds are constrained (or captured) by ordinary language, whereas revisionist naturalist rejects this claim. The hope that one of these two types of naturalism can meet both criteria 2.1 and 2.2 is misplaced. The natural kind dysfunction (presuming it is a natural kind) will only fix the extension of *mental disorder* if revisionist naturalism is accepted. However, revisionist naturalism cannot guarantee that homosexuality will be excluded from the natural kind dysfunction (presuming it exists). In turn, homosexuality may be a mental disorder and medically treated on this basis. While conservative naturalism means that homosexuality will be excluded from the natural kind dysfunction (presuming it exists) in the developed world, it does not fix the extension of natural kinds between societies – homosexuality might fall within the natural kind dysfunction in other societies (and in turn, may be a mental disorder and medically treated on this basis).

This chapter is structured in the following way. Section two considers a problem for Wakefield's harmful dysfunction analysis, namely, that it might not be co-extensive with ordinary language – there might be examples of conditions that are caused by dysfunctions, but that health professionals and informed lay-people do not ordinarily call mental disorders and *vice versa*.[159] This problem leads to discussion of the relationship between natural kinds and ordinary language.

Murphy and Woolfolk (2000a) argue that Wakefield avoids this problem (that the harmful dysfunction analysis is not co-extensive with ordinary language) using black box essentialism and conservative naturalism. I am not convinced that Wakefield is a conservative naturalist. Whether Wakefield is a conservative naturalist is not pivotal to

[159] The problem that *dysfunction* may have a necessary evaluative component (and if so, it cannot pick out a natural kind) was discussed in section five of the previous section.

my argument. I am primarily interested in whether conservative or revisionist naturalism can show, for once and for all, that conditions such as homosexuality do not fall within the natural kind dysfunction (presuming it exists). (If so, then conditions such as homosexuality cannot be mental disorders, and so cannot be medically treated on this basis.) Hence, the remainder of this chapter considers the implications of *dysfunction* picking out a natural kind. More specifically, it considers the advantages and disadvantages of both conservative and revisionist naturalism, as they apply to my aim i.e. safeguarding against the medical treatment of conditions such as homosexuality.

Section three shows that the main advantage of conservative naturalism is that the natural kind dysfunction (presuming it exists) must be co-extensive with the way *dysfunction* is ordinarily used by health professionals and informed lay-people. As homosexuality is not ordinarily considered to be caused by a dysfunction in the developed world, then homosexuality cannot fall within the natural kind dysfunction. This means that a conservative account of the natural kind dysfunction (presuming it exists) meets criterion 2.2. In turn, homosexuality cannot be a mental disorder and so homosexuality may not be medically treated on the basis of being a mental disorder. Section four discusses the main disadvantages of revisionist naturalism (regarding safeguarding against the medical treatment of homosexuality), namely, that it cannot pick what is included in a natural kind and so homosexuality might fall within the natural kind dysfunction (presuming it exists). That is, a revisionist account of the natural kind dysfunction (presuming it exists) does not meet criterion 2.2. Section five considers the disadvantages of conservative naturalism and the advantages of revisionist naturalism (as they relate to safeguarding against the medical treatment of homosexuality) These have not been separated into separate sections because they are interrelated and need to be considered alongside each other. The main disadvantages of conservative naturalism are that because natural kinds are constrained by ordinary language, and ordinary language might change between cultures, conservative naturalism might not provide extensions of natural kinds that are fixed between societies i.e. it does not meet criterion 2.1. Revisionist naturalism avoids this problem, but cannot ensure that homosexuality will be excluded from the natural kind dysfunction (presuming it exists).

The addendum (section eight) considers whether a family resemblance account of natural kinds will achieve my aim of safeguarding against the medical treatment of conditions such as homosexuality. It concludes that even if *dysfunction* picks out a family resemblance natural kind, this may not safeguard against the medical treatment of conditions such as homosexuality. Family resemblance accounts of natural kinds might fit with ordinary language (criterion 2.2), but if so, then they will not fix the extension of *dysfunction* between societies (criterion 2.1).

Overall, this chapter discusses the relationship between natural kinds (both essentialist and family resemblance) and ordinary language, and shows that neither conservative naturalism nor revisionist naturalism necessarily allows me to have my cake and eat it. Neither approach can guarantee that conditions such as homosexuality are excluded from the natural kind dysfunction (presuming it exists) and that this applies in all societies. Hence, neither conservative nor revisionist naturalism (regarding dysfunction) will safeguard against conditions such as homosexuality from being considered to be mental disorders. Nor will it safeguard against these conditions being medically treated on the basis of being mental disorders.

2. The Harmful Dysfunction Analysis is not a Good Fit with the way Mental Disorder is Ordinarily Used

There are multiple problems with Wakefield's harmful dysfunction analysis. As explained in section six of the previous chapter, many people have argued that *dysfunction* cannot pick out a natural kind because it has a necessary evaluative component. This section focuses on the argument that the harmful dysfunction analysis might not be co-extensive with ordinary language. However, for the sake of thoroughness, I shall first briefly turn my attention to two other potential problems for Wakefield.

Firstly, Wakefield's 'harm' requirement might be critiqued. This could occur in three ways. Firstly, it could be argued that the way *mental disorder* is ordinarily used by health professionals and informed lay-people does not have an evaluative component. However, as argued in section 4.1 of chapter five, the theory that *mental disorder* (as used by health professionals and informed lay-people) has no evaluative component has "few adherents" (Murphy, 2015, 19; see also Murphy, 2005, 116). Secondly, it could be

argued that while *mental disorder* does have an evaluative component, the evaluative component is not harm but say, incapacity (Sadler and Agich, 1995, 224). Thirdly, Wakefield says that whether a condition is harmful is not determined by the individual or some objective account of harm (i.e. whether a condition is harmful is not relative to the individual or society in question) but is instead determined by society (Wakefield, 2005, 88).[160] This is problematic because some societies may deem homosexuality to be harmful, and so it may be a mental disorder. Indeed, in a very homophobic society, being gay is likely to be harmful. Hence, homosexuality might be a mental disorder (if it is also caused by a dysfunction), and so may be medically treated on this basis. It could be argued that homosexuality is only harmful due to the prejudices and discrimination of certain cultures. That is, it could be argued that homosexuality is only harmful in homophobic societies due to sociocultural factors rather than biological factors. However, the problem with this approach is that there is no easy way to draw a clear line between the two (Kendell, 1975, 455). Bingham and Banner take the similar but stronger view that to distinguish between social and biological environments amounts to an "artificial polarisation", and that in any case, it would not be desirable for medicine to use such a narrow account of harm (Bingham and Banner, 2014, 540). In this way, Wakefield's account of harm is problematic, and a robust investigation of 'how the value-statuses of mental conditions are determined' is required.

These three problems concerning Wakefield's harm requirement are not discussed further. This is because in comparison to the large amount of debate generated by Wakefield's account of dysfunction, his 'harm' requirement has received relatively little attention.[161] Moreover, I am interested in the relationship between natural kinds and ordinary language which is not directly relevant to the 'harm' component.

Secondly, Aucouturier and Demazeux critique Wakefield for assuming *dysfunction* picks out a natural kind i.e. assuming *dysfunction* picks out a unified object of inquiry. They point out that just because we have the concept *mental disorder* in ordinary language does not mean that mental disorder is out in the world waiting to be discovered (Aucouturier & Demazeux, 2014, 80-81). As explained above, Wakefield thinks *dysfunction*, not *mental disorder,* picks out a natural kind. Aucouturier and Demazeux's

[160] See also section 4.1 of chapter five.
[161] An exception is Bengt Brülde, 2010.

idea is right; they just apply it to the wrong concepts. That is, just because we have the concept of *dysfunction* in ordinary language does not mean that *dysfunction* picks out a natural kind. While it might be beneficial to my project if *dysfunction* referred to a natural kind (because the extension of *dysfunction* would arguably be static over societies), this does not have any bearing on whether *dysfunction* does pick out a natural kind. What I want to be the case is not necessarily the case. Rather than presuming that *dysfunction* picks out a natural kind, Wakefield needs to show that it picks out a natural kind.

Let's now consider the claim that Wakefield's harmful dysfunction analysis is not co-extensive with the way in which *mental disorder* and *dysfunction* are ordinarily used by health professionals and informed lay-people. Wakefield thinks that his analysis of *mental disorder* corresponds with the ordinary, clinical sense of *mental disorder.* That is, Wakefield thinks that all conditions that fall within the clinical sense of *mental disorder* are mental disorders according to the harmful dysfunction analysis. He also thinks that all conditions that do not fall within the clinical sense of *mental disorder* will not be mental disorders according to the harmful dysfunction analysis. Not everyone agrees that Wakefield's harmful analysis is co-extensive with the ordinary clinical sense of *mental disorder.* Murphy and Woolfolk (2000a) argue that there are three situations in which Wakefield's account might not fit with ordinary language. That is, there are three situations in which a condition that is ordinarily called a mental disorder might not be caused by a dysfunction.

Firstly, Wakefield presumes that all beneficial mechanisms are functions—that all beneficial mechanisms have been naturally selected. Murphy and Woolfolk point out that this might not be the case as some beneficial mechanisms might be spandrels (Murphy & Woolfolk, 2000a, 276). Spandrels are advantageous by-products of other traits, but they do not have any adaptive functions in themselves (Gould & Lewontin, 1979). For example, the ability to read might be a spandrel i.e. a by-product of some mechanism that has been selected for (Murphy & Woolfolk, 2000a, 276). Murphy and Woolfolk reason that since a spandrel does not have an adaptive function, a spandrel cannot be a dysfunction in the sense that Wakefield uses that term. Hence, if the ability to read is a spandrel, the inability to read cannot be caused by a dysfunction (Murphy

and Woolfolk, 2000, 242-243).[162] While we consider the inability to read to be caused by a dysfunction, if the ability to read is a spandrel, then dyslexia is not caused by a dysfunction according to Wakefield's analysis. In turn, dyslexia could not be a mental disorder. Wakefield's harmful dysfunction analysis would conflict with the ordinary clinical sense of *mental disorder.*

Secondly, Murphy and Woolfolk claim that some mental disorders are caused by problems in the environment rather than a dysfunction within the individual (Murphy and Woolfolk, 2000, 243-244). If a smoke detector is placed too close to the oven, then the alarm will go off in the absence of fire. In this case, the smoke detector is not dysfunctional – smoke detectors were not designed to be placed near ovens. Instead, the problem is in the environment i.e. that the smoke detector is placed near the oven. By analogy, the mainstream view is that Attention Deficit Hyperactivity Disorder (ADHD) is both caused by a dysfunction and a mental disorder. However, if children were not designed to be in the formal classroom environment (Timimi and Taylor, 2004; Conrad and Potter, 2000), then hyperactivity in the classroom cannot be caused by a mental dysfunction, according to Wakefield's account. In short, it is arguable that ADHD is not caused by a dysfunction even though it is ordinarily called a mental disorder. Hence, Wakefield's harmful dysfunction analysis conflicts with the ordinary clinical sense of *mental disorder*.[163]

Thirdly, Murphy and Woolfolk claim that some mental disorders are not caused by dysfunctions but by 'bad input' (Murphy and Woolfolk, 2000, 244-245). For example, Anti-Social Personality Disorder might be caused by 'bad input'. If a child is consistently told that they are bad or stupid (if they are given bad inputs), then he or she might develop an anti-social personality. Arguably, those people who develop an anti-social

[162] Similarly, the female orgasm may be a spandrel, which means that a woman's inability to orgasm cannot be caused by a dysfunction (Murphy & Woolfolk, 2000, 249).

[163] By analogy, in an obesogenic environment, a person may become severely overweight. This does not necessarily mean obesity is caused by a dysfunction i.e. that something has gone wrong in the obese person. This is because it is plausible that humans were designed to have an affinity for sweet and fatty food because this would be beneficial in hunter-gatherer environments in which food is scarce (Breslin, 2013). Rather than obesity being caused by a dysfunction, it is possible that the problem is in the obesogenic environment. If correct, then we should consider not speaking of obesity as a 'disease' or using phrases such as the 'obesity epidemic'.

personality for these reasons are not dysfunctional, but are responding in an expectable way to an abusive childhood. [164]

In addition to Murphy and Woolfolk's three scenarios, there are also situations in which a condition might be a caused by a harmful dysfunction but does not fall within the ordinary clinical sense of *mental disorder.* For example, it might be that homosexuality is caused by a dysfunction. If reproduction is functional and gay people are less likely to reproduce, then homosexuality might be caused by a dysfunction (Cooper, 2005, 18; 2002, 269).[165] If so, and if homosexuality is also considered harmful, then homosexuality would be a mental disorder according to the harmful dysfunction analysis. Since homosexuality is not ordinarily called a mental disorder in the developed world, this would be an example in which the harmful dysfunction analysis conflicts with the current ordinary clinical sense of *mental disorder*.[166]

In short, Wakefield's harmful dysfunction analysis might conflict with the way *mental disorder* is used in ordinary language i.e. the clinical sense of *mental disorder.* There are two main ways in which one could respond to this conflict. Firstly, we could reject the harmful dysfunction analysis. That is, we could maintain that the extension of *mental disorder* must match ordinary language, and because the harmful dysfunction analysis does not match ordinary language, it must be rejected. Secondly, we could accept the harmful dysfunction analysis. If the harmful dysfunction analysis is accepted, then one of four options could to be taken. Firstly, we could adapt the harmful dysfunction analysis, so that rather than claiming that all mental disorders must be caused by a dysfunction, all mental disorders must have the right antecedent cause (Murphy, 2005; 2015). The phrase 'right antecedent cause' signifies that disvalue is insufficient to demarcate (mental) disorders, without making a commitment as to what the right antecedent cause is.[167] This would mean that the conceptual analysis of *mental disorder*

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[164] Wakefield claims that only those reactions that are unexpected (or abnormal or disproportionate) are dysfunctional (Wakefield, 1997, 646). See also Horwitz and Wakefield on post-bereavement grief (Wakefield, 2013a; Horwitz and Wakefield, 2007) and Horwitz and Wakefield on normal anxiety (Wakefield, 2000a, 258; Horwitz and Wakefield, 2012) *c.f.* Murphy and Woolfolk (2000; 2000a).
[165] *C.f.* Wilson's (1978; 1975) kin theory of homosexuality in which gay people pass on their genes not via direct reproduction but by playing a role in raising their nieces and nephews.
[166] See also the gourmand lesion and male aggression examples in section three of chapter six.
[167] If this approach is accepted, then the way in which *mental disorder* is used by health professionals and informed lay-people will be essentialist, albeit a vague essentialist account. As Varga points out, the necessary and sufficient elements of a concept may be vague, but this does not mean that the concept cannot be essentialist (Varga, 2011, 8; see also Cooper, 2014, 41).

would fit with ordinary language.[168] However, to say that all mental disorders must have the right antecedent cause without specifying what that cause consists of is rather vague. All it says is that according to the way health professionals and informed lay-people ordinarily use *mental disorder,* all mental disorders must be χ, and what χ amounts to is an open question. To say that all mental disorders must have the right antecedent cause is just as banal as saying that we have a folk theory of human nature in which a mental disorder occurs when something has gone wrong in that person's mind (see Murphy and Woolfolk, 2000a, 281 on 'view three'). In addition, as χ has not been specified, this approach cannot determine whether a condition is a mental disorder. For these reasons, this option is not discussed any further.

Secondly, it could be argued that the ordinary clinical sense of *mental disorder* is co-extensive with the harmful dysfunction analysis because all those conditions that fall within the ordinary clinical sense of *mental disorder* must be caused by a dysfunction. In other words, it could be argued that it is an empirical fact that the condition in question is caused by a dysfunction. For example, it would be said that dyslexia, ADHD or anti-social personality disorder must be caused by a dysfunction, and we need to keep looking for the dysfunction until we find one. (If it cannot be shown that the condition in question is caused by a dysfunction, then at some point, one of the other options would need to be adopted.)

Thirdly, it could be argued that the ordinary clinical sense of *mental disorder* is co-extensive with the harmful dysfunction analysis because *dysfunction* picks out a natural kind and natural kinds are constrained by ordinary language. This is different from the previous approach in which it is an empirical fact that the condition in question is caused by a dysfunction. In contrast, on this (third) approach, the condition in question is not caused by a dysfunction for conceptual reasons (*c.f.* empirical reasons). That is, the condition in question is not caused by a dysfunction due to the constraint of ordinary language.

[168] If the 'dysfunction' requirement is replaced with the 'right antecedent cause', then the extension of *mental disorder* may change based on how the 'right antecedent cause' is specified. For example, if the right antecedent cause is, at Wakefield suggests, being caused by a dysfunction, then the stress caused by the death of a loved one might not fall within the extension of *mental disorder.* On the other hand, if the right antecedent cause includes environmental stressors such as bereavement, then post-bereavement grief may fall within the extension of *mental disorder.*

Finally, we could accept the harmful dysfunction analysis, including the claim that all mental disorders must be caused by a dysfunction, and that *dysfunction* picks out a natural kind. We could then claim that dysfunction-status is not constrained by ordinary language. In this case, either a) the natural kind dysfunction would not be co-extensive with ordinary language or b) ordinary language could be revised to be co-extensive with the natural kind dysfunction. On the former approach, the extension of the natural kind dysfunction might not map exactly on to the way it is used by health professionals and informed lay-people. For example, dyslexia, ADHD and anti-social personality disorder might not be caused by a dysfunction (and so cannot be mental disorders), and homosexuality might be caused by a dysfunction (and so might be a mental disorder). On the latter approach, ordinary language would need to be updated or revised so that dyslexia, ADHD and anti-social personality disorders are no longer considered to be caused by a dysfunction (and so cannot be mental disorders). Equally, ordinary language would be revised so that homosexuality is caused by a dysfunction (and so might be a mental disorder). As explained in section one of chapter five, science might influence ordinary language such that the applicable science has become part of ordinary language. For example, that water is H^2O is a scientific discovery, but it is a scientific discovery that has been incorporated into ordinary language.

These options are summarised below: [169]

1. Reject the harmful dysfunction analysis. The condition (e.g. dyslexia) remains within the clinical sense of *mental disorder.*
2. Accept the harmful dysfunction analysis.
    a. Rather than being caused by a dysfunction, all mental disorders must have the right antecedent cause. The revised version of the harmful dysfunction analysis would be co-extensive with ordinary language.
    b. It is an empirical fact that the condition in question is caused by a dysfunction. The harmful dysfunction analysis is co-extensive with ordinary language.

[169] Murphy and Woolfolk list similar options, excluding options 2a and 2b (Murphy and Woolfolk, 2000a, 276).

c. The natural kind dysfunction (presuming it exists) is constrained by the way *dysfunction* is used in ordinary language. The harmful dysfunction analysis is co-extensive with ordinary language.
d. The natural kind dysfunction (presuming it exists) is not constrained by the way *dysfunction* is used in ordinary language. In this case, the ordinary sense of *dysfunction* either a) might not be co-extensive with the natural kind dysfunction or b) is revised to be co-extensive with the natural kind dysfunction.

The following section shows that Murphy and Woolfolk (2000a) argue that Wakefield takes approach 2c i.e. that Wakefield thinks that natural kinds are constrained by ordinary language. Option 2c is, according to Murphy and Woolfolk, an aspect of Wakefield's black box essentialism. As will emerge, I think Murphy and Woolfolk have misinterpreted Wakefield. However, it is still important to consider black box essentialism (and conservative naturalism) as such a position might be able to show that conditions such as homosexuality do not fall within the natural kind dysfunction (presuming it exists) (criterion 2.2), and that this applies across all societies (criterion 2.1).

3. Black Box Essentialism and Conservative Naturalism

As discussed in section six of the previous chapter, a consequence of Wakefield's use of an evolutionary account of function and dysfunction is that it makes it difficult to determine whether a condition is caused by a dysfunction because there is no blueprint of evolutionary processes. This is a methodological or epistemological problem (Murphy and Woolfolk, 2000, 247, 250). According to Murphy and Woolfolk, Wakefield seeks to avoid this problem using black box essentialism (Wakefield, 2000; 1999a).

As a black box essentialist, Wakefield thinks that we can know that a kind is a natural kind without knowing what the real essence of the kind is—the real essence might be locked in a black box. For example, Wakefield says that we knew that water was a natural kind before it was found that water is H_2O. Prior to Lavoisier's discovery that water is H_2O, the real essence of water was locked in a black box—it was unknown. Lavoisier unlocked the black box of water when he found that the essence of water is

H_2O. Just as Lavoisier unlocked the black box by finding the formula for water, Wakefield claims that Darwin and other evolutionary theorists have unlocked the black boxes of function and dysfunction to show that the essence of function is aetiological—the function of an organ or system is the effect for which it was naturally selected (Wakefield, 1992a, 243-244; 1999a, 471-472; 2000, 36). In other words, functions are effects that explain their causes (Wakefield, 1992, 381-383). By extension, a dysfunction is a failure of a mechanism within an organism to perform the function for which it was designed (Wakefield, 2007, 152; see also section five of the previous chapter). For my purposes, Wakefield's claim that aetiology is the real essence of function and dysfunction is not particularly important. Instead, the important point is that Wakefield claims that we can know that *dysfunction* picks out a natural kind, even if the real essence of dysfunction had not been determined. This is important because it leads to the discussion of the relationship between natural kinds and ordinary language.

As mentioned earlier, Aucouturier and Demazeux critique Wakefield for assuming *dysfunction* (or *mental disorder*) picks out a natural kind i.e. saying that we intuitively know that *dysfunction* picks out a natural kind. Although Aucouturier and Demazeux do not refer to Wakefield's black box essentialism, their argument can be read as a critique of black box essentialism – just because we have *dysfunction* in ordinary language does not mean that the real essence of dysfunction is locked in a box, and is out there waiting to be unlocked. It might be that *dysfunction* does not pick out a natural kind.

Murphy and Woolfolk (2000a) interpret black box essentialism as the claim that we can know the extension of a natural kind even though the real essence is locked in a black box. They claim that Wakefield is saying that we have intuitive knowledge of whether a condition falls within the natural kind dysfunction. For example, we can intuitively know that schizophrenia falls within the natural kind dysfunction and that being able to see is not a dysfunction. In other words, Murphy and Woolfolk say that Wakefield thinks that natural kinds are constrained by ordinary language. (This is presumably because ordinary language reflects the intuition that schizophrenia is caused by a dysfunction, but being able to see is not.) We do ordinarily think of schizophrenia as being caused by a dysfunction, so schizophrenia must fall within the natural kind dysfunction. Equally, we do not ordinarily think of seeing as being caused by a dysfunction, so vision cannot

fall within the natural kind dysfunction. Murphy and Woolfolk do not think that Wakefield merely claims that natural kinds must reflect ordinary language. Instead, the pair make the stronger claim that Wakefield says that natural kinds are constrained by ordinary language (Murphy and Woolfolk, 2000a, 284). The position that natural kinds are constrained by ordinary language is known as conservative naturalism (Murphy, 2015, 10). Conservative naturalism is a form of naturalism because it concerns natural kinds. It is conservative because it remains faithful to ordinary language i.e. to our folk theory about the natural kind in question. That is, it conserves the ordinary language meaning of the kind being considered. The opposing position – that natural kinds should not be constrained by ordinary language – is known as revisionist naturalism. Conservative naturalists might object to the idea that ordinary language 'constrains' natural kinds. They might prefer the idea that ordinary language 'captures' natural kinds i.e. that we can intuitively know whether a kind is a natural kind, and what is included or excluded from the kind. However, as will be shown in section six of this chapter, ordinary language does not always reflect natural kinds. Hence, I continue to refer to ordinary language 'constraining' natural kinds, rather than 'capturing' them.

Revisionist naturalism is naturalist because it concerns natural kinds. It is revisionist insofar as it claims that what counts as a natural kind and the extension of a natural kind might be revised based on new scientific findings. For example, imagine that a) *dysfunction* were found to pick out a natural kind and b) the natural kind dysfunction excluded dyslexia. A revisionist naturalist would claim that we need to revise the ordinary language idea that dyslexia is caused by a dysfunction. We would need to accept that dyslexia is not caused by a dysfunction. (Revisionist naturalists take option 2(d)(b) listed at the end of the previous section.) In contrast, the conservative naturalist would claim that dyslexia must be caused by a dysfunction because the natural kind dysfunction is constrained by the way *dysfunction* is used in ordinary language. (Conservative naturalists take option 2(c).)

I endorse Murphy and Woolfolk's account of conservative naturalism i.e. that conservative naturalists think that natural kinds not only reflect ordinary language, but are constrained by ordinary language. However, as will be shown in the remainder of this section, I am not convinced that Wakefield is a conservative naturalist. However, considering whether Wakefield is a conservative naturalist brings out a number of

features of conservative naturalism that require further inspection. Hence, sections three, four and five of this chapter consider the advantages and disadvantages of both conservative and revisionist naturalism (as they relate to safeguarding against the medical treatment of homosexuality) with a specific focus on whether either can show, for once and for all, that conditions such as homosexuality are not mental disorders.

3.1 Is Wakefield a conservative naturalist?

Murphy and Woolfolk's interpretation of Wakefield's black box essentialism is based on Wakefield's claim that some disvalued behaviours are not ordinarily considered to be symptoms of mental disorders because "we believe we were designed to react in that way" (Wakefield, 1999a, 64; see also Murphy and Woolfolk, 2000, 247). For example, we do not ordinarily consider the grief experienced after the death of a loved one to be caused by a dysfunction, because we believe that post-bereavement grief was designed for. Wakefield also says that calling post-bereavement grief a mental disorder "[flies] in the face of common sense about human nature" (Wakefield and Schmitz, 2014, 38). Murphy and Woolfolk say that Wakefield goes from our belief that post-bereavement grief is part of our design to the claim that post-bereavement grief cannot fall within the natural kind dysfunction. In turn, the pair conclude that Wakefield thinks the natural kind dysfunction is constrained by the way *dysfunction* is used in ordinary language i.e. that Wakefield is a conservative naturalist with regard to dysfunction. That is, Murphy and Woolfolk claim Wakefield says that, ordinarily, post-bereavement grief is not considered to be caused by a dysfunction (because we think it was designed for), and so post-bereavement grief cannot fall within the natural kind dysfunction. If Murphy and Woolfolk are correct about Wakefield's position, then while Wakefield's account of dysfunction might appear to be scientific, it is actually based in ordinary language. Wakefield would still be a naturalist insofar as he would claim that people intuitively know when a natural kind is represented. (The same applies to any other conservative naturalist.)

The example of post-bereavement grief suggests that Wakefield thinks that we can show that a condition must be excluded from the natural kind dysfunction based on ordinary language. In addition, Murphy and Woolfolk claim that Wakefield thinks we can show that a condition must fall within the natural kind dysfunction based on

ordinary language (Murphy and Woolfolk, 2000a, 288-289). This is based on Wakefield's claim that

> [We] do not have to know the details of evolution or of internal mechanisms to know, for example, that typical cases of thought disorder, drug dependence, mood disorders, sexual dysfunction, insomnia, anxiety disorders, learning disorders, and so on, are failures of some mechanisms to perform their designed functions; *it is obvious from surface features* (Wakefield, 1997c, 256, my emphasis).

To paraphrase, Wakefield thinks we can infer that some evolved mechanism is dysfunctional solely on the basis of abnormal behavior. This means Wakefield thinks that if we ordinarily consider some condition or behavior to be caused by a dysfunction, then that condition or behavior must fall within the natural kind dysfunction. For example, if I am very depressed for no good reason,[170] it makes sense (i.e. it is intuitive) to think that there must be some dysfunction occurring in my mind. Likewise, if I hear voices that are not there (if I am psychotic), then it seems to be obvious that my brain is not working as it should. Even though our understanding of psychosis is limited, Wakefield would think it is reasonable to presume that in the future, we will find a dysfunction that causes psychosis. In turn, it is reasonable to presume that psychosis constitutes a mental disorder. Hence, when looking for the real essence of dysfunction, we must look for something that includes psychosis and depression.

As psychiatry is in its infancy, there is very little reliable evidence concerning whether mental conditions such as depression and psychosis are caused by a dysfunction. Given this lack of evidence, it appears that in many cases, intuition about whether something has gone wrong drives dysfunction-status rather than dysfunction-status influencing our beliefs about whether something has gone wrong.[171]

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[170] A good reason, for example, might be being recently bereaved.

[171] Whether intuition drives function-status (or the other way around) might depend on why the condition is considered to be caused by a dysfunction. For example, if ADHD is caused by being in a mismatched environment rather than a dysfunction, then we might change our intuition that ADHD is a mental disorder. Equally, if Anti-Social Personality Disorder is not caused by a dysfunction but by bad input, then we might change our intuition that Anti-Social Personality Disorder is a mental disorder (*c.f.* Kirmayer and Young (1999) who critique Wakefield for using an evolutionary account of dysfunction which shifts attention from social learning and interactional problems.) In both these cases, function-status might drive our beliefs about whether something has gone wrong. In contrast, if dyslexia is not caused by a dysfunction (because the ability to read is a spandrel), we might be less likely to change our belief that dyslexia involves something going wrong. In this case, beliefs would drive function-status. Admittedly, my justifications for this are hazy – it is based on a hunch that most people would continue to call dyslexia a disorder (even if reading is a spandrel), but would be prepared to accept that ADHD is not a

Murphy and Woolfolk say Wakefield thinks people have a

> Capacity to identify real divisions in nature correctly and that science will subsequently provide the causal explanation of why the distinctions we make correspond to natural kinds. In the case of mental disorder, Wakefield would have it that common-sense distinguishes pathological and nonpathological behaviour and that evolutionary psychology vindicates our distinctions by showing how they are based on our design plan (Murphy and Woolfolk, 2000, 247).

In other words, Murphy and Woolfolk explain Wakefield's position by saying

> The scientific concept that Wakefield is interested in is the scientific application of a lay concept rooted in our everyday theory of human nature (Murphy & Woolfolk, 2000a, 286; see also Murphy, 2015, 26).

In short, Murphy and Woolfolk think Wakefield's black box essentialism has two components:

1. We can know that a kind is a natural kind without knowing what the real essence of the kind is.
2. We can know whether something falls within the natural kind without knowing what the real essence of the kind is. This is because natural kinds are constrained by ordinary language.

I am not convinced that Wakefield's black box essentialism includes the second component.[172] I think that Wakefield might be a black box essentialist without claiming that the natural kind is constrained by ordinary language. That is, I am not convinced that Wakefield is a conservative naturalist. For example, one could claim a) we can know that water is a natural kind without knowing the real essence of water, without claiming b) that all the stuff we ordinarily call water must fall within the natural kind water. I am not convinced that Wakefield is a conservative naturalist because, at multiple points in his response to Murphy and Woolfolk, Wakefield hints that while our intuitions provide a starting point for investigating natural kinds, intuitions are not hegemonic i.e. they can be overturned by empirical evidence. If correct, this would make

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mental disorder (if it is caused by a mismatched environment) and that Anti-Social Personality Disorder is not a mental disorder (if it is caused by bad input). For more on this see Pickering, 2003.
(Thank you to the overseas examiner for pointing out that there is a debate concerning whether intuition drives function-status or *vice versa*.)

[172] This includes both sentences of the second component i.e. that we cannot know whether something falls within a natural kind without knowing the real essence thereof, because natural kinds are constrained by ordinary language.

Wakefield a revisionist naturalist, as opposed to a conservative naturalist.[173] For example, Wakefield says,

> Local values sometimes reflect the most accessible evidence we have so we use it as a *first approximation. We often go wrong as a result* (Wakefield, 2000a, 265, my emphasis).

He also says that his sadness-generator example (which theorises that some sadness might be designed for) is not a polished theory, and,

> It does make some assumptions (based on evidence from the psychology of emotions) about sadness as a designed response *that could turn out to be incorrect. …* Local values about what is appropriate must enter into the consideration of what is proportional … but the use of local proportions is merely part of a *provisional (fallible)* theory of local indicators of function and dysfunction (Wakefield, 2000a, 266, my emphasis).

Likewise, Wakefield says of dyslexia that,

> The failure to learn to read under the right circumstances leads one to believe that the most plausible *(but still of course possibly incorrect)* hypothesis is one of dysfunction (Wakefield, 2000a, 267, my emphasis).

These three quotes suggest that Wakefield does not think that natural kinds are constrained by ordinary language. Our intuitions are a 'first approximation' and 'fallible'. Murphy and Woolfolk claim that Wakefield is not carrying out traditional conceptual analysis, but that he is carrying out a new sort of conceptual analysis in which folk theories (i.e. ordinary language) is incorporated into scientific theories (Murphy and Woolfolk, 2000a, 287). Traditionally, ordinary language theorists thought that science (i.e. empirical research) was not directly relevant to conceptual analysis. For example, as *bachelor* means unmarried, adult male, science could not find that there was a married bachelor. As Murphy and Woolfolk say, "empirical research could not discover anything germane to the question whether bachelors were married" (Murphy and Woolfolk, 2000a, 286). As explained in section one of chapter five, ordinary language theorists do not consider this to be an attack on science, but say that

[173] Put another way, methodological black box essentialism (which is aligned with revisionist naturalism) claims that intuitions provide a starting point for whether something is included within a natural kind. In contrast, metaphysical black box essentialism (which is aligned with conservative naturalism) claims that intuitions fix the extension of a natural kind. Murphy and Woolfolk claim that Wakefield is both a methodological and metaphysical black box essentialist. I say that Wakefield might only be a methodological black box essentialist.

philosophy is concerned with conceptual analysis whereas science is concerned with discovering the facts.

Ordinary language theorists claim that science is not directly relevant to concepts such as *bachelor* (which is not a natural kind). Conservative naturalists who are doing traditional conceptual analysis take this position in a slightly different direction and claim that science is not directly relevant to natural kinds i.e. that empirical evidence cannot tell us about the extension of a natural kind. Murphy and Woolfolk say that Wakefield is not doing this traditional conceptual analysis, which allows Wakefield to appeal to science to determine the extension of a natural kind. Instead, Murphy and Woolfolk claim that Wakefield is carrying out a new conceptual analysis in which,

> our commonsense theories of the world functionally define their theoretical concepts by specifying roles that they must satisfy. Science then discovers whatever it is in the world that satisfies the functional role specified by the folk theory. Science thus solves what Jackson (1998) calls "the location problem": fitting our commonsense beliefs into the scientific fabric of the world (Murphy and Woolfolk, 2000a, 288).

Murphy and Woolfolk explain Wakefield's erratic appeal to empirical findings (as evidenced in the quotations above) by claiming that Wakefield is carrying out this new type of conceptual analysis. On this new conceptual analysis, ordinary language constrains natural kinds. People doing this sort of conceptual analysis claim that this is not anti-scientific because, according to them, reality is not hidden by our everyday categories i.e. that science does not represent reality more accurately than everyday categories. The opposing view, as discussed in section six of this chapter, is that ordinary language does not necessarily map on to natural kinds and so ordinarily language obstructs a clear view on reality. On this new conceptual analysis, ordinary language is not just a heuristic device but is hegemonic i.e. ordinary language constrains natural kinds. The three quotations from Wakefield above suggest that he does not think that ordinary language is hegemonic. In turn, this suggests that Wakefield is not carrying out this new method of conceptual analysis i.e. that Wakefield is not a conservative naturalist doing this new type of conceptual analysis. On the other hand, Wakefield does say that the dysfunction-status (dysfunction being a natural kind) of a condition is obvious from surface features (Wakefield, 1997c, 256). Wakefield cannot both claim that we can know the dysfunction-status of a condition and that this

'knowledge' is fallible. Wakefield either has to claim that we can a) know the dysfunction-status of a condition based on surface features (conservative naturalism) or b) make the strong hypothesis that a condition is caused by a dysfunction, but admit that this hypothesis is fallible (revisionist naturalism). Murphy and Woolfolk think that Wakefield takes the first approach (in which ordinary language is hegemonic i.e. constrains science). However, I maintain that it is not clear which of these options Wakefield takes.

An additional argument which supports the view that Wakefield might not be a conservative naturalist is that Kripke and Putnam are not conservative naturalists but revisionist naturalists. As Wakefield uses Kripke and Putnam's account of natural kinds, if he wants to remain true to their account, then nor would Wakefield be a conservative naturalist. That Kripke and Putnam are revisionist naturalists is evidenced by their argument that if there were some stuff that had all the superficial or ordinary properties of water (i.e. stuff that was a clear, potable liquid found in lakes and rivers and so on), but this stuff was not H^2O, then that stuff would not fall within the natural kind water (Putnam, 1973; 1975; see also section four of chapter six). That is, if such stuff were found then the way *water* is used in ordinary language would need to be revised to exclude this stuff.

Whether Wakefield is a conservative naturalist is not pivotal to my argument. That is, whether Wakefield is a conservative naturalist does not determine whether conservative or revisionist naturalism will show that conditions such as homosexuality do not fall within the natural kind dysfunction (presuming it exists) (criterion 2.2), and that this applies across all societies (criterion 2.1). This question – whether conservative naturalism might meet both criteria – is considered in the next section.

4. Advantages of Conservative Naturalism

In the developed world, homosexuality is not ordinarily called a mental disorder by health professionals and informed lay-people. Hence, a potential way of ensuring that homosexuality does not fall within the natural kind dysfunction (presuming it exists) is to claim that the extension of the natural kind dysfunction is constrained by the way dysfunction is used in ordinary language i.e. to adopt conservative naturalism. That is conservative naturalism might meet criterion 2.2. By adopting conservative naturalism, the natural kind dysfunction (presuming it exists) would necessarily be co-extensive

with the way *dysfunction* is used in ordinary language. All conditions that are included within the way *dysfunction* is used in ordinary language will be included in the natural kind dysfunction. Equally, all conditions that are excluded from the way *dysfunction* is used in ordinary language will be excluded from the natural kind dysfunction.

That conservative naturalism means that natural kinds are co-extensive with ordinary language leads to two further advantages. The first is that a natural kind and its ordinary language counterpart refer to the same thing (or set of things). In other words, the natural kind dysfunction (presuming it exists) cannot stray so far from the way in which it is ordinarily used that the talk is no longer of *dysfunction* (as it is ordinarily used) but of something else i.e. something with a new intension and/or extension. In contrast, as explained in the following section, on revisionist naturalism, it is possible that the natural kind dysfunction (presuming it exists) will no longer refer to the same thing or set of things as the ordinary extension of *dysfunction.*

The second advantage is that conservative naturalism means that the pragmatic link between mental disorder and medical treatment will be retained. Chapter four showed that there is a pragmatic link between medical treatment and the way *mental disorder* is ordinarily used by health professionals and informed lay people i.e. that only mental disorders may be medically treated on the basis of being mental disorders. Conservative naturalism means that the natural kind dysfunction is co-extensive with the way *dysfunction* is ordinarily used by health professionals and informed lay people. For example, if dyslexia is ordinarily thought of as being caused by a dysfunction, then it must fall within the natural kind dysfunction (presuming it exists). In turn, dyslexia might be a mental disorder, and may be medically treated on this basis. Likewise, conservative naturalism means that if homosexuality is not ordinarily thought of as being caused by a dysfunction, then it cannot fall within the natural kind dysfunction (presuming it exists) and so cannot fall within the ordinary clinical sense of *mental disorder.* In turn, homosexuality may not be medically treated on the basis of being a mental disorder. More generally, as, a) the natural kind dysfunction is a necessary component of *mental disorder,* and b) conservative naturalism means that only those things that are ordinarily considered to be caused by a *dysfunction* can be included in the natural kind dysfunction (presuming it exists), then it follows that *mental disorder* (as ordinarily used by health professionals and informed lay-people) includes only

those conditions that are ordinarily considered to be caused by *dysfunctions.*[174] While the pragmatic link is between the ordinary clinical sense of *mental disorder* and medical treatment, conservative naturalism means that the natural kind dysfunction (presuming it exists) will only include those conditions that would ordinarily be called mental disorders. Hence, the pragmatic link between mental disorder and medical treatment would remain. (While this is an advantage of conservative naturalism, the next section shows that revisionist naturalism does not forsake the pragmatic link.)

In short, the advantage of conservative naturalism is that the natural kind dysfunction (presuming it exists) is co-extensive with the way *dysfunction* is ordinarily used – the natural kind dysfunction (presuming it exists) and the ordinary use of *dysfunction* refer to the same set of things. This means, for example, since homosexuality is not ordinarily considered to be caused by a dysfunction in the developed world, homosexuality cannot fall with the natural kind dysfunction (presuming it exists), and in turn, homosexuality can neither be a mental disorder nor be medically treated on the basis of being a mental disorder. In this way, the pragmatic link between mental disorder and medical treatment is retained (only mental disorders may be medically treated on the basis of being mental disorders), and so conservative naturalism might safeguard against the medical treatment of homosexuality.

To safeguard against the medical treatment of conditions such as homosexuality on the basis that these conditions are not disorders, it must be shown that these conditions are not mental disorders in any society. That is, it must be shown that the extension of *mental disorder* is static between societies and excludes these conditions i.e. both criteria 2.1 and 2.2 must be met. This section has shown that conservative naturalism means that the extension of *mental disorder* will exclude these conditions. (Section six of this chapter will show that conservative naturalism cannot provide an extension of *mental disorder* that is static between societies.) The following section considers whether revisionist naturalism will show that these conditions are not mental disorders.

[174] To be a mental disorder, a condition must be both harmful and be caused by a dysfunction. Hence, not all conditions that we ordinarily think of as being caused by dysfunctions are disorders, for example, Regard and Landis' (1997) gourmand lesion.

5. Disadvantages of Revisionist Naturalism

For the most part, the advantages of conservative naturalism concerning the natural kind dysfunction (presuming it exists) are the disadvantages of revisionist naturalism concerning the natural kind dysfunction (presuming it exists), and *vice versa.* As will be shown, an exception is the pragmatic link between mental disorder and medical treatment – both conservative and revisionist naturalism might retain the pragmatic link. This section shows that revisionist naturalism is disadvantageous (regarding safeguarding against the medical treatment of homosexuality), insofar as the natural kind dysfunction (presuming it exists) might not be co-extensive with the way *dysfunction* is ordinarily used. In other worlds, the two might not refer to the same set of things. This means that revisionist naturalism might not meet criterion 2.2. The section then shows that revisionist naturalism can retain the pragmatic link between mental disorder and medical treatment (so long as *mental disorder* does not fall out of common parlance).

According to revisionist naturalism, a natural kind is not constrained by the way a concept is used in ordinary language. Hence, the natural kind dysfunction (presuming dysfunction is a natural kind) might not be co-extensive with the way *dysfunction* is used in ordinary language. Homosexuality, for example, might fall within the natural kind dysfunction even though it is not ordinarily considered to be caused by a dysfunction in the developed world. In turn, homosexuality might be a mental disorder and medically treated on this basis. In this way, revisionist naturalism would not safeguard against the medical treatment of homosexuality (on the basis that it is not a mental disorder). Revisionist naturalism does not allow us to pick and choose what is included or excluded from the natural kind dysfunction (presuming it exists). It does not meet criterion 2.2. In contrast, conservative naturalism does meet criterion 2.2, as that the extension of a natural kind is constrained by ordinary language, and in this sense, we can choose what is included within the natural kind dysfunction (presuming it exists). Hence, conservative naturalism might safeguard against homosexuality being a mental disorder, and being medically treated on this basis.

As explained in the previous section, conservative naturalism means that the extension of *dysfunction* cannot stray so far from its ordinary use that the two no longer refer to the same thing i.e. that the talk is no longer of *dysfunction* (as it is ordinarily used) but of

something else. This is not necessarily the case for revisionist naturalism – the natural kind dysfunction (presuming it exists) might stray so far from the way *dysfunction* is ordinarily used, that the talk might no longer be of dysfunction (as it is ordinarily used), but something else (Murphy, 2015, 7). For example, imagine the natural kind dysfunction (presuming it is a natural kind) excludes depression and cancer. According to revisionist naturalism, depression and cancer would not be caused by a dysfunction even though they are ordinarily considered to be caused by a dysfunction. Equally, if the natural kind dysfunction includes happiness and intelligence, then according to revisionist naturalism, happiness and intelligence are caused by a dysfunction even though they are not ordinarily considered to be caused by a dysfunction. If this discrepancy happens multiple times, then the natural kind dysfunction might not mean the same thing as the way *dysfunction* is ordinarily used.

Murphy does not specify how far the ordinary meaning of a concept might stray before it becomes 'too far'. That is, he does not isolate the point at which the talk is no longer about *dysfunction*[175] (as it is ordinarily used) but something else. In Murphy's defence, it would be incredibly difficult to isolate such a point. Saying that the natural kind has strayed too far from ordinary language, if *mental disorder* falls out of the common vernacular (see section two of chapter five) does not help as there is no single point at which a concept will fall out of the common vernacular. It could be said that the talk is no longer about *dysfunction* (i.e. the ordinary language concept) in cases in which a natural kind no longer refers to substantially the same set of things as the ordinary use. But what does 'substantially' mean? That is, how much overlap does there need to be between the extension of the way *dysfunction* is ordinarily used (by health professionals and informed lay-people) and the natural kind dysfunction (presuming it exists)? Has the natural kind dysfunction (presuming it exists) strayed too far if only ninety percent of the types of conditions that fall within the ordinary extension of *dysfunction* fall within the natural kind dysfunction (presuming it exists) or *vice versa*? Or is eighty percent more acceptable? I do not solve this problem on behalf of Murphy, but merely wish to point out that his claim ought, at some point, to be refined.

[175] Murphy discusses the point at which the talk is no longer about *mental disorder* (rather than *dysfunction*). However, Murphy's point can be applied to any concept/natural kind pair.

To return to my initial point, the revisionist natural kind dysfunction (presuming it exists) might stray so far from the way *dysfunction* is ordinarily used, that the two no longer refer to the same thing. If this occurs, then the pragmatic link between mental disorder and medical treatment might dissolve. For example, dyslexia, ADHD and anti-social personality disorder are all ordinarily called mental disorders, and so must fall within the ordinary clinical sense of *dysfunction* i.e. these conditions must be caused by a dysfunction. If these three conditions do not fall within the natural kind dysfunction (which, according to the revisionist naturalist, is not constrained by ordinary language), then these conditions cannot fall within the extension of *dysfunction.* (In turn, these conditions cannot be mental disorders.) The extension of the natural kind dysfunction (presuming it exists) will stray so far from the way *dysfunction* is ordinarily used, that we might stop using *dysfunction* altogether. In turn, we might stop using *mental disorder* altogether. In other words, if the extension of *mental disorder* excluded many things that we take to be paradigm examples of mental disorders and include many thinks that we would not ordinarily call mental disorders, then *mental disorder* might fall out of the common vernacular. If so, the pragmatic link between it and medical treatment cannot survive – we could not claim that only mental disorders may be medically treated on the basis of being mental disorders. In contrast, as conservative naturalism means that natural kinds are constrained by ordinary language, *dysfunction* (and in turn, *mental disorder*) is unlikely to fall out of the common vernacular. Hence, the pragmatic link might be retained.

It could also be argued that even if we keep using *mental disorder,* the pragmatic link might dissolve if the meaning has strayed too far from its ordinary use. However, this is not the case. The pragmatic link will not dissolve if conditions that are not ordinarily considered to be caused by dysfunctions (e.g. homosexuality) are included within the natural kind dysfunction (presuming it exists). Even if homosexuality falls within the natural kind dysfunction, it is not a mental disorder unless it is disvalued (and is mental as opposed to physical). In the developed world (in which homosexuality is not disvalued), it would remain the case that homosexuality is not a mental disorder and so may not be medically treated on this basis. Hence, the pragmatic link would remain. Of course, in societies in which homosexuality is disvalued (and if homosexuality is mental as opposed to physical), then it would be a mental disorder. The pragmatic link would not dissolve in societies that disvalue homosexuality. Queer-friendly people like myself

might want the pragmatic link to dissolve (because they do not disvalue homosexuality), but the pragmatic link would not dissolve. While revisionist naturalism might not safeguard against the medical treatment of homosexuality, this is not because the pragmatic link has dissolved. Instead, it is because, in these societies, homosexuality is a mental disorder, and so may be medically treated on this basis.

Nor will the pragmatic link dissolve if conditions that are ordinarily thought of as being caused by dysfunctions (e.g. dyslexia) are not included in the natural kind dysfunction (presuming it exists). This is because the pragmatic link, as I have outlined it, is that 'only mental disorders may be medically treated on the basis of being mental disorders'. It does not say 'only mental disorders may be medically treated'. Hence, even if dyslexia is not a mental disorder, it may still be medically treated – it just cannot be medically treated on the basis that it is a mental disorder.[176] The pragmatic link between mental disorder and medical treatment would remain even if many conditions that we ordinarily called mental disorders were found not to be caused by a dysfunction. That is, it would still be the case that mental disorders may be medically treated on the basis of being mental disorders.[177] Even though the pragmatic link would not dissolve if conditions that are ordinarily thought to be caused by a dysfunction do not fall within the natural kind dysfunction, the pragmatic link might become less useful. If all mental disorders may be medically treated and many non-disorders may be medically treated, then it could be argued that there is little point in determining the disorder-status of a condition. Instead, what is important is whether the medical treatment fulfills the standard bioethical criteria (see section five of chapter three) or whether the treatment passes muster according to values-based medicine.

To summarise, revisionist naturalism means that the extension of a natural kind might differ from the way a concept is ordinarily used. The natural kind dysfunction (presuming it exists) might stray so far from the ordinary use thereof, that the talk is no longer of *dysfunction* (as ordinarily used) but something else. (Revisionist naturalism means that criterion 2.2 might not be met.) In turn, the meaning of *mental disorder* might stray so far from the ordinary use thereof, that the talk is no longer of *mental*

[176] Alternately, we might accept that dyslexia is not a mental disorder and so may not be medically treated on this basis. In this case, the pragmatic link would remain.
[177] See section 4.3 of chapter four in which it is shown that a condition's being a disorder is sufficient but not necessary to establish a pragmatic link between disorder and medical treatment.

disorder (as ordinarily used) but something else. In contrast, conservative naturalism does not face these problems – it meets criterion 2.2. Conservative naturalism also retains the pragmatic link between mental disorder and medical treatment. However, I have shown that unless *mental disorder* falls out of the common vernacular, revisionist naturalism will also maintain the pragmatic link.

To safeguard against the medical treatment of conditions such as homosexuality on the basis that these conditions are not disorders, it must be shown that these conditions are not mental disorders in any society (criterion 2.1). Revisionist naturalism cannot ensure that the natural kind dysfunction (presuming it exists) will be co-extensive with ordinary language. In turn, revisionist naturalism cannot ensure the second condition is met i.e. that conditions such as homosexuality do not fall within the natural kind dysfunction (presuming it exists). Hence, these conditions might be mental disorders, and if so, they may be medically treated on this basis. Given the desire to exclude homosexuality from the medical sphere, this is a major problem for my application of revisionist naturalism.

6. Disadvantages of Conservative Naturalism and Advantages of Revisionist Naturalism

The main disadvantage of conservative naturalism is that the extension of natural kinds might not be static between societies i.e. it might not meet criterion 2.1. This is because, as will be shown in this section, conservative naturalism cannot account for scientific findings, at least, until the science is incorporated into ordinary language. As a) the ordinary extension of a concept might change between societies, and b) conservative naturalism means that natural kinds are constrained by ordinary language, it follows that the extension of conservative natural kinds might change between societies. For example, in a society that does not ordinarily consider homosexuality to be caused by a dysfunction, then in that society, homosexuality cannot fall within the natural kind dysfunction (presuming it exists). In contrast, if homosexuality is ordinarily considered to be caused by a dysfunction in society χ, then in society χ, homosexuality must fall within the natural kind dysfunction (presuming it exists). In society χ, homosexuality might be a mental disorder and medically treated on this basis. Section four explained that the main advantage of conservative naturalism is that it can ensure that conditions such as homosexuality will not fall within the natural kind dysfunction (presuming it

exists) in societies in which these conditions are not ordinarily called MENTAL DISORDERS or considered to be caused by dysfunctions i.e. it will meet criterion 2.2. Nonetheless, as conservative naturalism will not fix the extension of the natural kind dysfunction (presuming it exists), it does not fulfil the second criterion – it cannot safeguard against the medical treatment of conditions such as homosexuality on the basis that they are not mental disorders. In other words, this section shows that even if *dysfunction* picks out a conservative natural kind, this cannot ensure that conditions such as homosexuality are not mental disorders in any society.

As mentioned earlier, for the most part, the disadvantages of conservative naturalism are the advantages of revisionist naturalism (as they relate to safeguarding against the medical treatment of homosexuality) and *vice versa.* Hence, an advantage of revisionist naturalism (for my purposes) is that it ensures that the extension of natural kinds is static between societies. This means that the natural kind dysfunction (presuming it exists) will be static between societies (criterion 2.1). In turn, it can be determined for once and for all whether homosexuality falls within the natural kind dysfunction, and whether it might be a mental disorder. However, revisionist naturalism cannot ensure that homosexuality is excluded from the natural kind dysfunction because we cannot pick and choose what is included or excluded from a natural kind (criterion 2.2). Even if *dysfunction* picks out a revisionist natural kind, this cannot ensure that conditions such as homosexuality are not mental disorders in any society.

Let us look at the claim that revisionist naturalism means that the extensions of natural kinds are static. According to revisionist naturalism, whether something falls within a natural kind is not constrained by ordinary language, but is based on scientific evidence. For example, let's say that fish is a natural kind and that all fish are 'gill-bearing aquatic craniate animals that lack limbs with digits' i.e. this is the real essence of the natural kind fish. This means that for a creature to be a fish it must, amongst other things, have gills. At one point, whales were thought to have gills and so whales were ordinarily considered to be fish. Scientists then found that whales do not have gills but lungs. A revisionist naturalist would say that fish is still a natural kind and it still has the same essence, but that the extension of the natural kind fish must exclude whales. That is, a revisionist would revise the extension of the natural kind fish to exclude whales. A revisionist would also revise the extension of the natural kind mammal (presuming it

exists) to include whales.[178] In other words, a revisionist naturalist would use the scientific evidence to show that the extension of *fish* (as it was ordinarily used in the past) is not co-extensive with the natural kind fish. As explained in section four of chapter five, according to Kripke and Putnam's account of natural kinds, natural kinds are demarcated using their real essence, and the real essence of a natural kind is the same across all possible worlds (Kripke, 1980, 48). This shows that Kripke and Putnam are revisionists regarding natural kinds. For example, if fish is a natural kind, and the real essence thereof is along the lines of 'gill-bearing aquatic craniate animals that lack limbs with digits', then this is the case in all possible worlds. Hence, the extension of the revisionist natural kind fish is static across all societies. By analogy, the extension of the revisionist natural kind dysfunction (presuming it exists) would also be static across societies.

According to revisionist naturalists, science determines the real essence of a natural kind. Science also determines whether something possesses the real essence i.e. science determines membership of the natural kind.[179] While revisionist naturalists claim that natural kinds are not constrained by ordinary language, this does not mean that ordinary language is irrelevant to the extension of natural kinds. Ordinary language provides a starting point to determine whether a kind is a natural kind. As Murphy says, scientific and ordinary language uses of a concept are not

> "fully independent, since the development of science influences everyday thought, and many scientific concepts begin in prescientific contexts and carry the marks of those origins deep into their careers" (Murphy, 2015, 7).

However, revisionist naturalists say ordinary language is only a heuristic device. Ordinary language might reflect an intuition about whether a kind is a natural kind and what the extension of the natural kind is, but it cannot prove or disprove either of these things. That is, for revisionist naturalists, ordinary language is not hegemonic – ordinary

[178] 'Mammal' is not italicised because I am not considering the concept *mammal*, but the set 'mammals' itself.

[179] Revisionist naturalists do not necessarily claim that the way a concept is used in ordinary language should be changed to be co-extensive with a natural kind. For example, if there were some stuff that we would ordinarily call *water*, but this stuff is not H_2O, then that stuff would not fall within the natural kind water. However, we might still call this stuff *water* in ordinary language.

language is trumped by scientific evidence (Murphy, 2015, 25; see also Murphy and Woolfolk, 2000a, 289).

As explained in section one of chapter five, ordinary language theorists claim that science is not directly relevant to concepts that are not natural kinds such as *bachelor* (see also section 3.1 of this chapter). Ordinary language theorists argue that philosophy is concerned with conceptual analysis; whereas science is concerned with discovering the facts. I agree with the ordinary language theorists that empirical evidence is irrelevant to the extension of non-natural kinds such as *bachelor.* The extension of *bachelor* must be based on the way it is ordinarily used. To say there is a married bachelor would be to misunderstand the meaning of *bachelor.* Conservative naturalists take this position further, and claim that science is not directly relevant to natural kinds i.e. that empirical evidence cannot tell us about the extension of a natural kind. A conservative naturalist would maintain that during the time in which whales were considered to be fish, whales were fish i.e. that the natural kind fish (presuming it is a natural kind) must include whales. The conservative naturalist would also say that the natural kind mammal (presuming it is a natural kind) cannot include whales. For the conservative naturalist, whales would remain in the natural kind fish in spite of the scientific evidence that whales do not have gills. The conservative naturalist would not revise the extension of the natural kind fish (presuming it is a natural kind) based on the scientific finding that whales do not have gills. A conservative naturalist would either change the real essence of the natural kind fish so that it included whales, or say that *fish* cannot pick out a natural kind.[180] Conservative naturalists ignore the scientific evidence about the natural kind fish (presuming it is a natural kind) for purely conceptual reasons – it is decided 'from the armchair' that whales must be fish. The conservative naturalist would maintain that this is not anti-scientific because, according to them, our ordinary use of *fish* does not hide reality i.e. that science does not reflect the real world more precisely than ordinary language.

While conservative naturalists claim that science is not directly relevant to the extension of natural kinds, scientific findings might be indirectly relevant if they lead us to change the use of the word. For example, that 'whales do not have gills, but lungs' has

[180] Finding that whales (and other creatures such as lungfish (Zachar, 2000, 176)) do not have gills is unlikely to be sufficient to show that fish is not a natural kind.

led us to exclude whales from the ordinary language extension of *fish.* In turn, the extension of the natural kind fish (presuming it is a natural kind) now excludes whales. Equally, that 'whales do not have gills, but lungs' has led us to ordinarily call whales mammals. Hence, the extension of the natural kind mammal (presuming it is a natural kind) now includes whales. But why should we wait until science becomes part of ordinary language to revise the extension of the natural kind? If whales do not have gills, then whales should be excluded from the natural kind fish straight away. We should not have to wait until ordinary language evolves in such a way that whales are not ordinarily called fish before we can say that the natural kind fish excludes whales. In contrast, a revisionist naturalist does not have to wait for ordinary language to change to account for the scientific findings.

So far, it has been shown that conservative naturalism cannot account for scientific evidence (at least, until that evidence has been incorporated into ordinary language). Conservative naturalists claim that this is not anti-scientific because ordinary language does not hide reality i.e. that ordinary language maps on to the real world. I shall now show this to be false, or, at least, highly questionable. In some cases, our common-sense categories will be co-extensive with natural kinds. For example, everything that we ordinarily call *water* falls within the natural kind water. However, in many cases, common sense categories will not be co-extensive with natural kinds. For example, the way we use *jade* in ordinary language is two different natural kinds, namely jadeite and nephrite. While jadeite and nephrite produce minerals that appear very similar, jadeite is a combination of sodium and magnesium and nephrite is constituted of calcium, magnesium and iron (Putnam, 1975, 241). For a further example, water is a natural kind, but it is not intuitively clear that steam, ice and a single molecule of H_2O fall within the natural kind water.

A conservative naturalist might respond that jade is a single natural kind that includes both jadeite and nephrite. In turn, the conservative naturalist would maintain that ordinary language does map on to natural kinds. Conservative naturalists would say that this is acceptable because ordinary language tells us how nature is really organised i.e. that ordinary language does not obstruct a clear view on reality. I disagree. Instead, like Murphy and Woolfolk, I claim there is little reason to suppose that our ordinary language categories always conform to natural kinds (Murphy and Woolfolk, 2000,

247).[181] Sometimes ordinary language will conform to natural kinds (e.g. water), but to claim that an ordinary language category is co-extensive with a natural kind would be to make a substantial empirical bet. Conservative naturalists claim that their position is that natural kinds exist in the world, and ordinary language reflects these natural kinds. In contrast, what conservative naturalists really do, is to start with the way a concept is used in ordinary language, and claim that natural kinds reflect ordinary language. Moreover, that conservative naturalism cannot account for scientific findings at the time at which they are made puts conservative naturalism on shaky grounds. Ordinary language should not constrain the extension of natural kinds because to do so would not give science its deserved credence. Conservative naturalism merely pays lip-service to science. As Murphy and Woolfolk point out, conservative naturalism means that in cases in which "science agrees with folk-theory, it is to be commended, and where it does not, it is to be criticized" (Murphy and Woolfolk, 2000a, 291). I agree with Murphy and Woolfolk that this puts unnecessary and unfavourable restrictions on the scientific enterprise.

Let us now consider how conservative and revisionist naturalism would be applied to *dysfunction.* A conservative naturalist would say the natural kind dysfunction (presuming it is a natural kind) must include all and only those conditions we ordinarily think of as caused by a dysfunction. Conservative naturalists acknowledge that empirical evidence might be indirectly relevant to the extension of the natural kind dysfunction (and in turn the extension of *mental disorder*) if the empirical evidence led to changes in ordinary language. Revisionist naturalists would say that a condition can fall within the natural kind dysfunction (presuming it is a natural kind) regardless of whether it is ordinarily considered to be caused by a dysfunction. Revisionist naturalism can account for science immediately – without having to wait for the science to be incorporated into ordinary language.

Conservative naturalism might have unpalatable consequences for the natural kind dysfunction (presuming it is a natural kind). In nineteenth century Russia, epilepsy was

[181] Unless conservative naturalism is accepted, then we cannot know that a kind is a natural kind without knowing the real essence. That is, if conservative naturalism is rejected, then black box essentialism is false. We would not be able intuitively know whether something is a natural kind.

not ordinarily considered to be caused by a dysfunction, but was seen as a sign of holiness (Ruse, 1981**,** 149). Advances in medical science means that we now know that epilepsy is caused by a dysfunction. Conservative naturalists in societies that do not ordinarily consider epilepsy to be caused by a dysfunction would have to maintain that epilepsy does not fall within the natural kind dysfunction (presuming it is a natural kind) in spite of the scientific evidence.[182] They would have to ignore the scientific evidence purely for conceptual reasons. I agree with Murphy that whether a condition is caused by a dysfunction is not to be decided 'from the armchair' (Murphy, 2015, 26, see also Murphy and Woolfolk, 2000a, 286). Instead, to determine whether a condition is functional or not, we need to do science and scientific findings might result in common sense (i.e. ordinary language) being contradicted.[183]Equally, some societies ordinarily think of (or thought of) homosexuality as being caused by a dysfunction. Even if scientists find that homosexuality is not caused by a dysfunction, conservative naturalists in these societies must maintain that homosexuality falls within the natural kind dysfunction (presuming it is a natural kind) in spite of the scientific evidence. Once again, the scientific evidence would be ignored for conceptual, not empirical, reasons.[184]

A further problem for conservative naturalism is that it leaves the natural kind dysfunction (presuming it exists) open to be used for the purpose of social control. It is likely that the fact that we disvalue some condition influences the fact that the condition is ordinarily thought of as being caused by a dysfunction. That is, the logical positivists claim that 'sciences and values are independent' might be wrong – science might be influenced by values.[185] [186] If so, conservative naturalism means that the natural kind

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[182] The conservative naturalist could not account for the scientific evidence until that epilepsy is caused by a dysfunction has become part of ordinary language.

[183] Murphy claims that the way health-concepts, such as *mental disorder,* are used in ordinary language are too muddled to constrain science (Murphy, 2015, 13; see also Murphy 2006). (Note the similarity here with Aucouturier and Demazeux's (2014) claim that *mental disorder* is not unified in either ordinary language or in in scientific settings.) Yet, even if the way *mental disorder* were used in ordinary language were well-defined, Murphy says the ordinary language definition of *mental disorder* should not constrain the real essence of the natural kind dysfunction (presuming it exists) (Murphy, 2015; 2006; see also Murphy & Woolfolk, 2000a).

[184] It could be found that homosexuality falls within the natural kind dysfunction (presuming it exists). This is not problematic for the revisionist naturalist (i.e. my application of revisionist naturalism) because even though homosexuality would fall within the natural kind dysfunction, unless it is disvalued, then homosexuality cannot be a mental disorder.

[185] Quine, 1951. See section five of chapter six, and Murphy and Woolfolk, 2000, 246 *c.f.* Wakefield, 2001, 35. See also Nordby, 2006; Goldenberg, 2006, 2624; Zita, 1988, 79; Longino, 1983; Franklin and Perovic, 2015 and Cooper, 2005, 88. See

[186] The value-status of a condition could also be influenced in the other direction – values might be influenced by science. We might find (in a value-free way) that some condition is caused by a dysfunction,

dysfunction will be evaluative and culturally relative i.e. it will not really be a natural kind. In contrast, revisionist naturalism means that scientific evidence can override our ordinary categories, and so even if values do influence dysfunction-status, these values are not hegemonic i.e. they do not determine the function-status of a condition. (Whether a revisionist naturalist can completely purge the values is debatable. See, for example, section six of chapter five.) Wakefield critiques Sedgwick's purely normative (value-laden) definition of *mental illness* as it means that *mental illness* is

> A completely value and culture-relative notion with no scientific content whatsoever, thereby leaving the concept open to unconstrained use for purposes of social control (Wakefield, 1992, 376).

Wakefield implies that while Sedgwick's account of *mental illness has* "no scientific content whatsoever", his account of *disorder* does have scientific content (Wakefield, 1992, 376). However, if Wakefield is a conservative naturalist, then nor is his account of *dysfunction* scientific. His approach would also leave the concept of *mental disorder* open to social control. In societies that ordinarily consider homosexuality to be caused by a dysfunction, homosexuality would fall within the natural kind dysfunction (presuming it exists). In turn, homosexuality might be a mental disorder and may be medically treated on this basis.

On the other hand, as explained in the previous section, a major problem for revisionist naturalism, at least for my purposes, is that it cannot ensure that conditions such as homosexuality, masturbation, being a runaway slave and being a political dissident will not be mental disorders (criterion 2.2). While revisionist naturalism will provide a static extension of the natural kind dysfunction (presuming it exists)[187], we cannot pick and choose which conditions we want to be included in or excluded from the natural kind. In addition, if science has no obligation to respect ordinary language, then the natural kind might stray so far from the way in which it is ordinarily used that the two do not refer to

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which biases people towards disvaluing that condition. For example, it might be that homosexuality is caused by a dysfunction (see, for example, Cooper, 2005, 18; 2002, 269 *c.f.* Wilson, 1978; 1975). If so, we may begin to disvalue homosexuality i.e. to consider homosexuality to be harmful. It might be rebutted that this is a non-sequitur due to the divide between 'is' statements and 'ought' statements. However, in practice, it is possible that once a condition is known to be caused by a dysfunction, it will slowly become disvalued.

[187] If dysfunction picks out a natural kind, then it can be shown whether a condition (such as homosexuality) is caused by a dysfunction. Even so, it cannot show that homosexuality is not caused by a dysfunction.

the same thing (Murphy, 2015, 7). If this were to occur, then *dysfunction* and *mental disorder* could drop out of the common vernacular which would mean that the pragmatic link between mental disorder and medical treatment would be forsaken.[188]

There are a few options at this point. Firstly, revisionist naturalists could maintain that this does not matter – the natural kind should not be constrained by ordinary language in any respect.[189] This approach does not avoid the problem that natural kinds and ordinary language might not refer to the same thing. Hence, this approach might risk *dysfunction* falling out of ordinary language altogether, which would result in the pragmatic link being forsaken. Secondly, revisionist naturalism could avoid this problem (that natural kinds and ordinary language might not refer to the same thing) by allowing natural kinds to be constrained by ordinary language to the extent that the two refer to the same thing. The problem with this approach, as mentioned in the previous section, is that it would be difficult to specify this point. Moreover, it is not clear why revisionist naturalism should bow to ordinary language i.e. why it should be constrained by ordinary language in this respect. This point leads to the third option for revisionist naturalists, namely, to maintain that natural kinds should not be constrained by ordinary language even in this very minimal sense, but to acknowledge the difficulty by choosing a different word (i.e. rigid designator) to refer to the natural kind. For example, if scientists were to find that only half of the conditions we ordinarily think of as being caused by a dysfunction fall within the natural kind dysfunction (and that half of the conditions we do not ordinarily think of as being caused by a dysfunction fall within the natural kind), they could consider giving it a different name (i.e. rigid designator), such as 'zysfunction'. The problem with this approach is that, in ordinary language, all mental disorders are disvalued mental dysfunctions. It is not the case that all mental disorders are disvalued mental zysfunctions. Hence, whether a condition is caused by a zysfunction is irrelevant to whether that condition is a mental disorder. For example, even if the natural kind zysfunction excludes homosexuality, then this is irrelevant to whether homosexuality is a mental disorder. None of these options solve

[188] As explained in the previous section, the pragmatic link will not dissolve if conditions that are not ordinarily considered to be caused by dysfunctions are included within the natural kind dysfunction (presuming it exists).

[189] At times, Murphy and Woolfolk claim that ordinary language should not constrain natural kinds at all. For example, they say, "science is under no obligation to respect our pre-theoretic beliefs" (Murphy and Woolfolk, 2000a, 272). However, this is not representative of the overall tone of their papers.

the problem potentially faced by revisionist naturalists i.e. that homosexuality might be a mental disorder. Instead, my aim here was only to point out the seemingly intractable problems posed by the tensions between revisionist naturalism and ordinary language.

To summarise this section, the main disadvantage of conservative naturalism is that the extension of natural kinds might not be static between societies – it might not meet criterion 2.1. This is because the extension of ordinary language concepts such as *dysfunction* changes between societies and conservative naturalists claim that the extension of natural kinds are constrained by ordinary language i.e. conservative naturalists cannot account for scientific evidence until that evidence is incorporated into ordinary language. In contrast, revisionist naturalism means that the extension of a natural kind is static between societies. It can meet criterion 2.1. This is because revisionist naturalism claims that natural kinds are not constrained by ordinary language, and so it can account for scientific evidence without having to wait for ordinary language to catch up. Conservative naturalists say their position is not anti-scientific because ordinary language does not hide reality i.e. ordinary language maps on to the real world. However, it is not the case that ordinary language always maps on to the world and the extension of a natural kind should not be determined 'from the armchair'. Hence, in addition to not providing a static extension of natural kinds, conservative naturalism is anti-scientific.

Revisionist naturalism is also problematic, for my purposes, as it might mean that conditions such as homosexuality fall within the natural kind dysfunction (presuming it exists). It might not meet criterion 2.2. In turn, these conditions may be mental disorders, and medically treated on this basis. In addition, if the natural kind dysfunction strays too far from the way *dysfunction* is used in ordinary language, then *dysfunction* might fall out of use in ordinary language. If so, the pragmatic link between mental disorder and medical treatment might be lost.[190]

7. Conclusion

This chapter has considered the implications of *dysfunction* being a natural kind i.e. whether it will help to show, for once and for all, that conditions such as homosexuality

[190] The pragmatic link will not be lost if a) conditions that are not ordinarily considered to be caused by dysfunctions are included within the natural kind dysfunction (presuming it exists) or b) conditions that are ordinarily thought of as being caused by dysfunctions are not included in the natural kind dysfunction (presuming it exists).

are not mental disorders and so may not be medically treated on this basis. This led to the discussion between conservative naturalists (who claim that ordinary language constrains natural kinds) and revisionist naturalists (who deny conservative naturalism).

The chapter first questioned Murphy and Woolfolk's (2000; 2000a) claim that Wakefield is a conservative naturalist regarding dysfunction. They claim that Wakefield's black box essentialism means that he is a conservative naturalist. I am not convinced that Wakefield is a conservative naturalist. He might be a revisionist naturalist. I presented a different interpretation of Wakefield's black box essentialism in which he might not be a conservative naturalist. According to this interpretation Wakefield claims that 'we can know that a kind is a natural kind without knowing what the real essence of the kind is', without making the additional claim that 'we can know whether something falls within the natural kind without knowing what the real essence of the kind is'.

This chapter has considered whether conditions such as homosexuality are not mental disorders in any society. To be true, it must be shown that the extension of mental disorder

2.1 Is static between societies, and
2.2 Excludes conditions such as homosexuality.

Neither conservative nor revisionist naturalism can meet both criteria 2.1 and 2.2. Conservative naturalism can maintain that conditions such as homosexuality cannot fall within the natural kind dysfunction (presuming it exists) in the developed world, and so cannot be a mental disorder in the developed world. That is, conservative naturalism meets criterion 2.2, at least in the developed world. However, conservative naturalism does not fulfil criterion 2.1. Conservative naturalism means that in a homophobic society, the natural kind dysfunction (presuming it exists) might include homosexuality. Conservative naturalism does not show, for once and for all, that homosexuality does not fall within the natural kind dysfunction (and so cannot be a mental disorder). In contrast, if *dysfunction* picks out a revisionist natural kind, this might include conditions such as homosexuality. This because revisionist naturalism cannot pick what is included in a natural kind. Science tells us how nature is really organised, and that we want a

condition such as homosexuality to be excluded from the natural kind dysfunction (presuming it exists) is irrelevant to how nature is really organised. [191] Hence, even if *dysfunction* picks out a revisionist natural kind, then this may not fulfil criterion 2.2. However, if *dysfunction* picks out a revisionist natural kind, then this will provide an extension of *dysfunction* that is static between societies (criterion 2.1). In turn, the extension of *mental disorder* will be partly static between societies.

Even if *dysfunction* picks out a natural kind, neither conservative naturalism nor revisionist naturalism allows us to have our cake and eat it. Conservative naturalism meets criterion 2.2 but not criterion 2.1. Revisionist naturalism meets criterion 2.1 but not criterion 2.2. Neither conservative nor revisionist naturalism can show that societies that consider conditions such as homosexuality to be mental disorders are mistaken. In turn, this approach cannot show that those societies that medically treat conditions such as homosexuality on the basis of being mental disorders have incorrectly applied the rhetoric of mental disorder (i.e. that the wrong extension of *mental disorder* is used but correctly applied).

8. Addendum: Family Resemblance Natural Kinds and Conservative Naturalism

So far, this chapter has considered essentialist natural kinds and has shown that even if *dysfunction* picks out an essentialist natural kind, it cannot meet both criteria 2.1 and 2.2. Section 5.1 explained that Cooper's family resemblance account of natural kinds is a more relaxed account of natural kinds i.e. more kinds might be natural kinds than on the essentialist approach. Cooper argues that while her account relaxes the notion of natural kinds, it is still a realist account i.e. it provides the true extension of a natural kind. Artificial or accidental kinds will not be labelled family resemblance natural kinds because the network of criss-crossing and overlapping properties of a natural kind must be determining properties.[192] ('Determining properties' are those properties of family resemblance natural kinds that are linked together via natural laws such that inductive inferences can be made (Cooper, 2005, 49-51).) As a family resemblance natural kind is more relaxed, the hope is that if *dysfunction* is a family resemblance natural kind, then it

[191] This could be rejected by showing that ordinary language represents the word just as accurately as science does i.e. that ordinary language maps on (or is co-extensive with) natural kinds. However, ordinary language tells us how we intuitively organise nature, not how nature is really organised.
[192] See Cooper on Dupré (Cooper, 2005, 49-51) and section 5.1 of the previous chapter.

might meet both criteria 2.1 and 2.2. That is, the properties of the family resemblance natural kind dysfunction (presuming it exists) are picked out by health professionals and informed lay-people. This means that this family resemblance natural kind is amenable to conservative naturalism i.e. it is constrained by the way *dysfunction* is ordinarily used by health professionals and informed lay-people. In this way, the hope is that criterion 2.2 will be met – conditions such as homosexuality will not fall within the extension of *dysfunction.* Moreover, as the family resemblance natural kind dysfunction (presuming it exists) is a real category, the hope is that there will be a truth about the extension thereof. That is, it might provide an extension of *dysfunction* that is static between societies, and so meets criterion 2.1. This section shows that this is not the case – even if *dysfunction* picks out a family resemblance natural kind, it cannot meet both criteria 2.1 and 2.2. This is because, while family resemblance natural kinds are amenable to conservative naturalism, one can still be a revisionist family resemblance natural kind theorist. If *dysfunction* picks out a conservative family resemblance natural kind, it might meet criterion 2.2 but not 2.1. If *dysfunction* picks out a revisionist family resemblance natural kind, it might meet criterion 2.1 but not 2.2.

Two points need to be clarified. Firstly, not all family resemblance concepts are family resemblance natural kinds (see Aucouturier & Demazeux, 2014, 80-81 and section one of this chapter). A family resemblance concept is only a family resemblance natural kind if it has sufficient determining properties to form a property cluster. Henceforth, I work on the presumption that the way health professionals and informed lay-people use *dysfunction* picks out a family resemblance natural kind, and consider the implications of this i.e. whether it will fulfil both criteria listed above.[193] Secondly, section 5.1 of the previous chapter also explained that family resemblance natural kinds might be promiscuous i.e. a single concept might pick out multiple natural kinds depending on that in which we are interested (Cooper, 2005, 49; Duprè, 1981, 74). I am not interested in whether *dysfunction* picks out multiple family resemblance natural kinds depending on that in which we are interested. This section solely concerns the family resemblance natural kind dysfunction as used by health professionals and informed lay-people (presuming it exists). (Henceforth, referred to as the family resemblance natural kind

[193] See section 5.1 for how *dysfunction* (as used by health professionals and informed lay-people) may pick out a family resemblance concept.

dysfunction.) It does not concern other family resemblance natural kinds, such as that that might be used by pathologists.[194]

Now that these points have been clarified, I will show that the family resemblance natural kind dysfunction (presuming it exists) used by health professionals and informed lay-people cannot meet both criteria 2.1 and 2.2 – it cannot both show that conditions such as homosexuality are not mental disorders, and that this applies in all societies. As with essentialist natural kinds, which of the criteria are fulfilled depends on whether revisionist or conservative naturalism is accepted. As shown in section three of this chapter, the advantage of a conservative account of essentialist natural kinds is that it matches with ordinary language. The same applies to a conservative account of a family resemblance natural kind. According to a conservative account of family resemblance natural kinds, the extension of the family resemblance kind dysfunction is constrained by the way health professionals and informed lay-people ordinarily use *dysfunction.* If health professionals and informed lay-people (in the developed world) do not ordinarily consider homosexuality to be caused by a dysfunction, then it cannot fall within the family resemblance natural kind dysfunction, and so cannot be a mental disorder. In this way, family resemblance natural kinds are amenable to conservative naturalism, and so criterion 2.2 would be fulfilled.[195]

The disadvantages of a conservative account of essentialist natural kinds are twofold. Firstly, it cannot account for scientific findings until the science has been incorporated into ordinary language. Secondly, it cannot provide a static extension of the natural kind dysfunction. It cannot meet criterion 2.1. This is because it is constrained by ordinary language, and ordinary language changes between societies and within societies over time, and so the extension of the natural kind dysfunction would also change. These two disadvantages also apply to a conservative account of the family resemblance natural kind dysfunction. That is, a conservative family resemblance natural kind cannot account for science (until it has become part of ordinary language). Take, for example, a society in which health professionals and informed lay-people ordinarily consider

[194] As explained in section 5.1 of the previous chapter, on a family resemblance account of natural kind, the network of properties is between the properties of a concept, such as *dysfunction*, as used by a single group, such as health professionals and informed lay-people. The network is not between the natural kind *dysfunction* as used by multiple groups.

[195] While family resemblance natural kinds are amenable to conservative naturalism, this does not mean that all family resemblance natural kind theorists are conservative – they may be revisionists.

homosexuality to be caused by a dysfunction (such as China[196], Serbia or Indonesia). In these societies, homosexuality will be included in the conservative family resemblance natural kind dysfunction. Now imagine that scientists find that homosexuality is not caused by a dysfunction. According to this conservative account of the family resemblance natural kind dysfunction, homosexuality would remain in this family resemblance natural kind despite the presence of scientific evidence that refutes this categorisation. Despite the scientific evidence, homosexuality would remain in the family resemblance natural kind dysfunction until the relevant science has been incorporated into the ordinary language of health professionals and informed lay-people in these societies. This inability to account for science means that a conservative account of the family resemblance natural kind dysfunction might not provide a static extension of *dysfunction.* Homosexuality will not be included in the family resemblance natural kind dysfunction (presuming it exists) that is used by health professionals and informed lay-people in the West. However, in societies in which health professionals and informed lay-people do ordinarily consider homosexuality to be caused by a dysfunction (for example, modern China, Serbia and Indonesia), homosexuality will be included in the family resemblance natural kind dysfunction (presuming it exists) that is used by health professionals and informed lay-people in these societies. Hence, the extension of the family resemblance natural kind *dysfunction* will not be static between societies. Moreover, in societies in which homosexuality is included within the family resemblance natural kind dysfunction, homosexuality might be a mental disorder, and so may be medically treated on this basis.

In short, as conservative family resemblance natural kinds are constrained by ordinary language, and ordinary language changes between societies, the extension of the natural kind dysfunction will also change. This means that criteria 2.1 is not met – the extension of *dysfunction* is not static. In turn, it cannot be shown, for once and for all, that homosexuality is not a mental disorder. A conservative account of the family resemblance natural kind used by health professionals and informed lay-people (presuming it exists) will not safeguard against the medical treatment of homosexuality on the basis that homosexuality is not a mental disorder.

[196] While homosexuality is not a mental disorder according to the Chinese Society of Psychiatrist, in practice, it is considered to be a mental disorder (Human Rights Watch, 2017).

Let us now consider revisionist naturalism. The advantages of the revisionist account of essentialist natural kinds, for my purposes, are that it can account for science (it does not have to wait for the science to be incorporated into ordinary language) and so it will provide a static extension of *dysfunction* (see section six). The same applies to a revisionist family resemblance account of the natural kind dysfunction. There would be a truth concerning the extension of the family resemblance natural kind dysfunction, and this truth is not dependent on the ordinary language of the society in question. Criterion 2.1 would be met.[197] However, as shown in section five, for my purposes, the disadvantage of a revisionist account of the essentialist natural kind dysfunction (presuming it exists) is that it might not be co-extensive with ordinary language. This means that homosexuality might still fall within the revisionist essentialist natural kind dysfunction, even though we (i.e. health professionals and informed lay-people from the developed world) do not ordinarily think of homosexuality as being caused by a dysfunction. Criterion 2.2 would not be met. That we do not want homosexuality to fall in the natural kind dysfunction does not mean that homosexuality is excluded from the natural kind dysfunction. In slogan form, what we want to be the case is not necessarily the case. Hence, a revisionist account of the family resemblance natural kind dysfunction will not ensure that conditions such as homosexuality are not caused by a dysfunction. In short, a revisionist account of the family resemblance natural kind dysfunction as used by health professionals and informed lay people (presuming it exists) would provide a static extension of *dysfunction* (criterion 2.1). However, it might be that conditions such as homosexuality fall within the natural kind thereof (criterion 2.2). This would apply to all societies. In societies in which being gay is also disvalued, it may be a mental disorder and medically treated on this basis.

[197] A single concept may pick out multiple family resemblance natural kinds. As I am interested in the clinical sense of *dysfunction,* I have only discussed the family resemblance natural kind dysfunction used by health professionals and informed lay-people (presuming it exists). I have not discussed, for example, the family resemblance natural kind dysfunction used by pathologists (presuming it exists). The way *dysfunction* is used by health professionals and informed lay people may pick out a revisionist family resemblance natural kind, and the way *dysfunction* is used by pathologists may also pick out a revisionist family resemblance natural kind. If so, a condition could be caused by a dysfunction according to the family resemblance natural kind as used by health professionals and informed lay-people, but not caused by a dysfunction according to the family resemblance natural kind dysfunction as used by pathologists. If *dysfunction* picks out multiple family resemblance natural kinds, then a revisionist account of family resemblance natural kinds will not provide a static extension of *dysfunction.* That is, to provide a static extension thereof, the sense of *dysfunction* in which one is interested would need to be specified.

To conclude, neither a revisionist nor a conservative account of the family resemblance natural kind dysfunction as used by health professionals and informed lay-people (presuming it exists) meets both criteria 2.1 and 2.2. The conservative approach does not provide a static extension, but might exclude conditions such as homosexuality. A revisionist approach provides a static extension but might include conditions such as homosexuality. Neither approach allows us to both have our cake and eat it.

Chapter Eight – Are there fixed values concerning mental disorders?

1. Introduction

Chapter five showed that disvalue is a necessary component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people – if a condition is not disvalued, then it cannot be a mental disorder. If whether a condition is disvalued changes over time or culture, then the extension of *mental disorder* will change between these societies. For example, in societies in which homosexuality is not disvalued, then homosexuality cannot be a mental disorder and so cannot be medically treated on that basis. In contrast, if homosexuality is disvalued by a society, then it might be a mental disorder in that society. In turn, it may be medically treated on the basis of being a mental disorder in that society. That is, it would be appropriate for it to be medically treated on that basis. Chapter five also explained that the variable extension of *mental disorder* might be resolved if *mental disorder* referred to a real category. This chapter considers whether *mental disorder* picks out a morally real category i.e. whether there are truths concerning the value-status of a condition. Rather than asking whether a condition, in itself, is to be disvalued, it is asked whether a condition leads to things that are to be disvalued. For example, if the ability to distinguish reality from that which is not real is to be disvalued, and schizophrenia impedes this ability, then schizophrenia is to be disvalued. In turn, schizophrenia might be a mental disorder and if it is a mental disorder, schizophrenia may be medically treated on the basis of being a mental disorder.

What does it mean to say that *mental disorder* refers to or picks out a morally real category? Moral realists argue that for a claim to be morally true it must exist 'in the world' independent of human's beliefs and experiences. Moral realism faces multiple problems. For my purposes, the most important are that there might not be any such things as moral truths, and that it is unclear how we could have knowledge of a moral truth i.e. a morally real category. That is, moral realism faces metaphysical problems, as well as the problem of epistemological access. However, my goal is not to show that *mental disorder* is a morally real category, but to consider ways in which the extension of *mental disorder* might be fixed. This chapter avoids the epistemological problem by

grounding or justifying values in another way i.e. without appealing to moral realism. The chapter considers whether there are Rawlsian primary goods – goods that are of value no matter what plan of life one selects – concerning mental states. For example, if the ability to distinguish reality from that which is not real is a primary good, and schizophrenia impedes this ability, then schizophrenia is to be disvalued, and so might be a mental disorder. Equally, if being able to communicate with others is a primary good, and if severe anxiety impairs this primary good, then severe anxiety is to be disvalued. In turn, severe anxiety might be a mental disorder. More importantly, for my purposes, if some individual or society claimed that severe anxiety was not to be disvalued, then that person or society is wrong.[198] Equally, if being gay impairs a primary good, then homosexuality is to be disvalued and so might be a mental order. On the other hand, if homosexuality does not impair any primary good, then homosexuality is not to be disvalued, and so cannot be a mental disorder. Those people or societies that claim that homosexuality is to be disvalued (and so might be a mental disorder) are wrong. In the absence of primary goods concerning mental states, and if the extension of *mental disorder* cannot be fixed in some other way, then we cannot say that those who consider homosexuality to be a mental disorder are wrong. The most that we can say is that their extension of *mental disorder* is different to that used in the developed world.

This chapter considers whether there are primary goods related to mental states, what these are, and whether homosexuality impairs any of these primary goods. It also considers whether the existence of primary goods can fix the extension of mental disorder. Section two gives a brief overview of moral realism, and the opposing position, namely, moral anti-realism. It explains the problems faced by both camps and that these problems might be avoided by utilising Rawlsian primary goods. Section three begins by exploring Fulford's (1993; 1995) claim that the values associated with mental conditions are diverse, which suggests that there might not be primary goods concerning mental states, and so the extension of *mental disorder* might not be able to be fixed using this method. Section 3.1 considers Graham's argument that the basic psychological capacities are primary goods and any condition that impairs one or more of these capacities is to be disvalued. Varga (2015) argues that Graham's basic

[198] Presuming the ability to communicate is a primary good and that anxiety impairs this primary good.

psychological capacities are both too narrow (i.e. are not neutral between differing competing conceptions of the good life and too vague to be primary goods). I show both of Varga's claims to be misguided. While the basic psychological capacities are not too vague to be primary goods, the vagueness does mean that the capacities might be interpreted in different ways in different societies. Moreover, a condition might impair a capacity in some environments but not others. If either of these occurred, then a condition would be disvalued in some societies but not others. In turn, this means that the extension of *mental disorder* would not be static between societies. The basic psychological capacities will not help to determine, for once and for all, whether a condition is a mental disorder i.e. they do not help to meet criteria 2.1.

2. Moral realism and moral anti-realism

Moral realists claim that there are such things as moral truths.[199] Moral realists point out that some things are valued in almost all societies, such as friendship and bravery; and some things are disvalued in almost all societies such as murder and incest. In contrast, moral anti-realists claim that there are no such things as moral truths. Moral anti-realists generally adopt one of three positions: non-cognitivism, error theory or non-objectivism. Moral non-cognitivists claim that moral claims are the sorts of things that cannot be true or false i.e. moral claims are not truth-apt. They claim that moral statements such as 'murder is bad' or 'bravery is good' are either expressions of feelings (emotivism) or orders (prescriptivism). Error theorists, such as Mackie, claim that moral statements aim at the truth but fail to secure it because there is nothing that instantiates the moral property or there is no such property. Mackie (1977) says if moral truths existed, then they would do so in a very different way from anything else in the universe and so moral truths would be ontologically queer. The final type of moral anti-realists, namely moral non-objectivists, claim that moral facts exist but are constituted by mental activity.

[199] These moral truths might or might not be relative to the society in question. However, if they are relative to the society in question, then this will not do for my purposes. If 'homosexuality is to be disvalued' is a moral truth in one society, but 'homosexuality is not to be disvalued' is a moral truth in another society, then moral truths will not fix the extension of *mental disorder* and so might not safeguard against the medical treatment of homosexuality.

Moral anti-realists point out that moral realists face the epistemological problem of how we determine whether something is a moral truth (presuming moral truths exist).[200] When determining the truth of empirical matters, we use our sense-experience, for example, when we examine the natural world. If Mackie is right that moral truths are ontologically queer, then sense experience cannot determine the truth of a moral claim.[201] In addition, the divide between 'is' statements and 'ought' statements means that we cannot base moral truths on the way things are. In other words, that there are such things as moral truths cannot be deduced from the claim that there are moral claims that are universally held. Universal moral claims do, however, make the existence of moral truths more plausible.[202] Anti-realists also claim that it is difficult to get widespread agreement on moral truths in many areas – there is much cultural diversity on what is moral or immoral. For example, in some cultures, infanticide would be acceptable whereas in others, it would not.[203] Nor can we claim that our current ideological standards necessarily reflect the moral truth. For example, just because infanticide is currently seen as immoral, this does not mean that it is immoral. Unless moral claims progress over time (which is debatable), we cannot say that current ideological standards are any better than past ideological standards.

There are, of course, problems for anti-realism. One of the most important is that moral anti-realism might slide into an 'anything goes' situation.[204] This would mean, for example, that infanticide is acceptable in societies which consider it to be acceptable, that slavery is acceptable according to the norms of a slave society, and the medical treatment of homosexuality is acceptable in a homophobic society. Without a moral truth to appeal to, moral realists need a different way in which to ground their claim

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[200] Varga argues that the ontological status of values is irrelevant and that what matters is the epistemological problem of how we pick out the right values (Varga, 2015, 205).
[201] Here, I presume that something cannot be ontologically queer and sensible i.e. that ontological queerness means that the truth cannot be captured by the usual five senses.
[202] Equally, even if it is difficult to get widespread agreement on many moral truths does not mean there are no moral truths. However, it does mean that the existence of moral truths is less plausible.
[203] Realists respond that anti-realists exaggerate diversity since there are often underlying shared agreements. For example, both societies might think that the suffering of a baby should be minimised. Societies that think that infanticide is acceptable take this stance because they want to reduce the suffering of babies.
[204] Many moral anti-realists, such as Rorty (1989) reject that their position means anything goes. They claim that the beliefs and practices of a society can be judged by the norms of that society and by the norms of external societies. Hence, moral anti-realists can still judge the beliefs and practices of other cultures, but they maintain that there is no neutral, 'god's eye' standpoint by which morality can be determined.

that one position is right or wrong or that one position is better than another. One way a moral realist could avoid this problem is to adopt a more relaxed account of moral realism, such as Thornton's (2007) 'relaxed naturalism'.[205] Thornton argues that values are real in the same way that secondary properties such as colour are real. According to Locke (and McDowell, upon whose work Thornton bases his argument), secondary qualities are not in the object itself, but are caused in us by powers in the object. The powers are the secondary qualities and the powers are in the world. Hence, secondary qualities are real. Thornton argues that values are real in the same way. Relaxed naturalism means that if naturalism is concerned with getting to the structure of the world, and values form part of the structure of the world, then values can be natural (Thornton, 2007, 234-236).[206] As Varga says, relaxed naturalism allows Thornton to "have it both ways" (Varga, 2015). That is, Thornton can admit that *mental disorder* is value-laden but real. For my purposes, the important part of Thornton's argument is that if *mental disorder* picks out a relaxed natural category, then the claim that a condition is a mental disorder can be right or wrong. When we disagree about the boundaries of *mental disorder,* it is possible that one side is wrong.[207]

Relaxed naturalism is not discussed further for two reasons. Firstly, as secondary qualities exist (as powers) in the real world, it still faces the epistemological problem of determining what the secondary qualities are. Secondly, Thornton is a particularist

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[205] As naturalism is a type of moral realism, Thornton is a (relaxed) moral realist.
The debate concerning conservative and revisionist naturalism (see sections four to six of chapter seven) can also be applied to strict moral realism. If there are such things as moral truths concerning the extension of mental disorder, then these form a real kind. Should real moral kinds (presuming they exist) be constrained by people's values? Conservative naturalists regarding real moral kinds claim that the kinds should be constrained by people's values. Hence, conservative naturalists regarding real moral kinds are likely to be relaxed moral realists. (Relaxed moral kinds are dependent on the values of people, and so relaxed moral realists necessarily claim that moral truths are constrained by the values of people.) In contrast, as revisionist naturalists regarding real moral kinds maintain that the kind should not be constrained by the values held by people, revisionist naturalists are likely to be strict moral realists.

[206] Varga argues that values are different from secondary properties in two ways (Varga, 2015, 200-204). Firstly, secondary properties are stable. For example, green things are always seen as green. In contrast, values are unstable - an individual can change their mind regarding an evaluative state. Secondly, while secondary properties are largely agreed upon, values are divergent i.e. they change over time and culture. These differences mean that while secondary properties may be relaxed naturalistic categories, values might not be.

[207] In contrast, Wakefield does not claim there are moral truths regarding the value-status of mental conditions i.e. he claims that what is considered harmful may change between societies (Wakefield, 2005, 89 *c.f.* Boorse, 2014, 690; 2012, 7, see also Varga, 2015, 196, 204). Hence, while Wakefield's harmful dysfunction analysis (1992) has both descriptive and evaluative components, Wakefield's approach does not have it both ways i.e. Wakefield does not claim that *mental disorder* has an evaluative component, and refers to a real category. Instead, Wakefield says that *dysfunction* is a real category i.e. a natural kind.

rather than a principlist (Thornton, 2008, 125; 2007, 233). That is, Thornton thinks that values cannot be codified into principles, but instead depend on the particulars of the context in question. (Thornton argues that this does not mean that values are subjective – he says they are real but uncodifiable.) Thornton's claim that values cannot be codified is problematic for my purposes because it will not be able to help determine whether a type of condition is a mental disorder. For example, if whether homosexuality is disvalued depends on the context in question, then it cannot be said that homosexuality is always to be valued or disvalued. In turn, it cannot be determined, for once and for all, whether homosexuality might be a mental disorder. If Thornton's particularism is correct, then moral realism will be unable to achieve what I hope that it might – to provide a static extension of *mental disorder.* Hence, I do not discount Thornton's account because I think it is wrong, but because it cannot help my project.

A second potential way of a) avoiding the problems of moral realism and anti-realism and b) showing that the extension of *mental disorder* is fixed is to show that the value-status of mental states are fixed between people and societies. This approach is agnostic in the moral realism/anti-realism debate. That is, it does not require the values to be real (or say that real values do not exist), but aims to show that the value-status of mental states is fixed. That approach is considered in the following section.

3. Is the value-status of mental states fixed?

This section considers whether the value-status of mental states is fixed. [208] If the value-status of all mental states is fixed, then the extension of *mental disorder* will be, at least partly, fixed.[209] For example, if it is the case that being able to be responsible and care for oneself is to be valued by everyone, and dementia impedes this ability, then dementia is to be disvalued. If dementia is also caused by a dysfunction, and mental (as opposed to physical), then dementia would be a mental disorder. This would apply to all societies. Someone who says that dementia is not to be disvalued, and so cannot be a mental disorder, would be wrong. The same line of reasoning can be applied to physical

[208] Wakefield would ask whether the condition leads to harm. I take harm to be a type of disvalue, but do not use the term 'harm' because Wakefield hints that there are not moral truths regarding mental disorder (Wakefield, 2005, 89), whereas I am agnostic on the existence of moral truths concerning mental states.

[209] For the extension of *mental disorder* to be entirely fixed, it must also be the case that there is a truth about whether the condition is caused by a dysfunction, and whether it is a mental condition (as opposed to a physical condition).

disorders. If being free of pain is to be valued by everyone, since having a broken arm is painful, then having a broken arm is to be disvalued. If having a broken arm is caused by a dysfunction and physical, then having a broken arm must be a physical disorder in all societies. (I presume that the intension of *physical disorder* is 'disvalued physical dysfunctions'.)

The values involved in physical disorders are widely agreed upon (Fulford, 1993). For example, nearly everyone thinks having cancer or a broken arm is a bad thing, and nearly everyone thinks that the ability to see is a good thing.[210] In contrast, Fulford claims that there is much diversity in those mental conditions that are valued and disvalued. There is, of course, some agreement on the value-status of mental disorders. Most people would agree that the mood disturbances involved in depression and inability to care for oneself caused by dementia should be disvalued. However, Fulford's point is that the values concerning mental states are much more diverse than the value-status of physical disorders. Fulford points out, for example, that while extreme sportspeople love the rush of adrenalin that comes from anxiety, others hate it (Fulford, 1993, 159; 1995, 155).[211] This means that the value-status of anxiety is not fixed. Anxiety might be a mental disorder for some people but not others, which means that the extension of *mental disorder* will not be fixed.

How does this relate to whether it can be shown, for once and for all, that homosexuality is or is not a mental disorder? If 'the ability to be in a romantic relationship with the person you love' is to be valued by everyone and if homosexuality does not impede this, then homosexuality is not to be disvalued (on this basis), and so homosexuality could not be a mental disorder (on this basis). Equally, if 'being able to have a biological child with your partner' is to be valued by everyone, and

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[210] This widespread agreement means that the values become less visible (and hence the values can be translated into descriptive terminology). However, this does not mean that the concept *physical disorder* is value-free (see Fulford *et. al.*, 2005, 80). Following Hare, Fulford says that where values are shared, they will be less obvious and hence the thing will appear fact-heavy. In contrast, where values are diverse (as mental states are), they will be obvious, and hence the thing in question will appear value-heavy.

[211] It could be argued that whether something is to be valued depends on whether it leads to happiness. For my purposes, the problem with this approach is that something may lead to happiness for one person but not another. Hence, this approach will not fix the extension of *mental disorder* between individuals, let alone between societies. For example, the anxiety I experience prior to public speaking does not make me happy – I disvalue it and so it may be a mental disorder. However, other more extroverted people, may still feel anxiety before public speaking, but thrive on it. For such people, the very same type of anxiety leads to happiness and so is valuable. Hence, it cannot be a mental disorder for these people, but it may be a mental disorder for me.

homosexuality prevents a gay person from having a biological child with his or her same-sex partner, then homosexuality is to be disvalued, and so a) might be a mental disorder and b) medically treated on this basis.

There are two problems with this line of reasoning. Firstly, it is unlikely that 'being in a romantic relationship with the person you love' is to be valued by everyone. Some hermits and people with autism might maintain that loving is not always good. Moreover, there are situations in which we think being in such a relationship might not be a good thing, such as when a person loves a violent partner, or is in an incestuous relationship with a parent. In addition, a homophobic person would say that it is not good for a person to be in a romantic, loving relationship with someone of the same sex. Likewise, the ability to have a biological child with your partner is unlikely to be valued by everyone, as evidenced by the growing number of couples who choose not to have children or their biological children (OECD, 2015). Some people would also say that the ability to have children is not a good if the parents are incapable of raising a child, for example, if the parents are too young, too old, too poor, too busy and so on.

Secondly, even if 'being in a romantic relationship with the person you love' is to be valued by everyone, whether being gay impedes this depends on the environment in which one is in. It would not be impeded in a queer-friendly environment, and so homosexuality is not to be disvalued (on this basis). In a homophobic environment, being gay might impede this good, and so in homophobic environments, homosexuality is to be disvalued. This problem is returned to in section 3.1.3 of this chapter.

The values relating to mental states that have been considered so far (anxiety, being in romantic relationships, and the ability to have biological children) are not fixed i.e. these things are not to be valued by everyone. The following section considers whether the values of mental states might be fixed using Graham's (2013) basic psychological capacities.

3.1 Graham's basic psychological capacities

Graham uses Rawls' 'original position' methodology to determine the goods concerning mental states. Rawls (1999) says that to take the 'original position', we are placed behind a veil of ignorance. Behind this veil, we do not know what type of cultural, economic or any other relevant circumstances we are in. Rawls thinks that behind this

veil of ignorance, rational agents would ensure that society is organised so they can realise the goods that are required for any life to go well. That is, the veil of ignorance is said to provide neutrality between the different conceptions of the good life no matter what plan of life one selects i.e. things that are primarily good (Graham, 2013, 150-152).[212] Having sufficient food, water and shelter are examples of primary goods.

Graham uses Rawls' 'veil of ignorance' methodology to pick out those mental capacities that are primary good i.e. those mental capacities that all rational agents would pick regardless of their plan of life. Graham begins by pointing out that capacities for both reason (including reason-responsiveness) and consciousness are basic psychological goods, and then list seven further basic psychological goods (Graham, 2013, 157-159):

1. Bodily and spatial self-location – to be able to identify the physical position of our bodies in the world so that we can use their motor capacities to achieve goals.
2. Historical and temporal self-location – to be able to identify our present position in time and as individuals with a past and a future.
3. General self-comprehension and world-comprehension – the ability to comprehend both ourselves and the world to the extent that enables us to live in a moderately well-informed and knowledgeable fashion.
4. Communication – the ability to communicate about ourselves and the world with other people, and to be both competent speakers and listeners.
5. Care, commitment and emotional attachment and engagement – the ability to care about and be committed to people and things other than ourselves.
6. Responsibility for self – the ability to care and be responsible for ourselves, to guide and control our behaviour in a reason-responsive way.
7. Recognising and acting on opportunities.

Graham claims that these basic psychological capacities are primary goods. This means that if a condition impedes one of these capacities, then that condition is to be disvalued. For example, if schizophrenia hinders general self-comprehension and world-comprehension, then schizophrenia is to be disvalued. Anyone who claims that schizophrenia is not a mental disorder (because it is not the case that schizophrenia is

[212] Rawls says that the primary goods identified behind the veil of ignorance presumes that one is in a democratic nation state that has a level of wealth.

to be disvalued) would be wrong. Graham also distinguishes between a decent life and a flourishing life. If an impairment of the basic psychological capacities impacts negatively on a decent life, then the condition might be a mental disorder. In contrast, if the impairment impacts negatively on a flourishing life, then the condition is not a mental disorder (Graham, 2013, 159-160).

Graham develops a prototypical – non-essentialist – account of *mental disorder.* On his account, even if the condition does not impair a basic psychological capacity, so long as enough of the other requirements, such as having harmful consequences, are fulfilled, then the condition is a mental disorder (Graham, 2013, 148, 165). Hence, a prototypical account such as Graham's will not determine, for once and for all, whether a condition is a mental disorder. I make a slight change to Graham's position and apply Graham's basic psychological capacities to an essentialist account of *mental disorder* – a condition might be a mental disorder if and only if it impairs a basic psychological capacity (in such a way that it impacts negatively on a decent life). For example, if schizophrenia hinders general self-comprehension and world-comprehension, then schizophrenia is to be disvalued and so might be a mental disorder. If schizophrenia is also caused by a dysfunction and mental (as opposed to physical), then it is a mental disorder. By taking this essentialist approach to the basic psychological capacities, it might be determined, for once and for all, whether a condition is a mental disorder.

Now that Graham's position has been outlined, it can now be considered whether the basic psychological capacities are primary goods. Graham's basic psychological capacities are much more fundamental and expansive than the potential fixed values mentioned above. For example, I asked whether 'the ability to have a biological child with one's partner' and 'being in a romantic relationship with the person you love' are to be valued by everyone. In contrast, Graham says that the ability 'to care about and be committed to people and things other than ourselves' is a primary good. This expansiveness is advantageous as it makes it much more likely that Graham's basic psychological capacities will be primary goods i.e. it allows neutrality between the various conceptions of the good life. Regardless of whether someone wants to have children, it is likely that having emotional commitments to others is a primary good.

Three questions arise from Graham's list. Firstly, are the basic psychological capacities primary goods? Secondly, will they help to determine whether a condition is a mental

disorder? Thirdly, will the basic psychological capacities provide an extension of *mental disorder* that is fixed between cultures?

3.1.1 Are the basic psychological capacities primary goods?

Regarding the first question (whether Graham's basic psychological capacities are primary goods), Varga argues that the basic psychological capacities are both too vague and too narrow to be primary goods i.e. that they would not be universally picked out based on their importance in realising a good life.[213] Regarding narrowness, Varga says, there are examples in which the basic psychological capacities might not be chosen by all rational agents behind the veil of ignorance. For example, Varga points out that monks and warriors might have a conception of the good life in which it would be better for them not to have a capacity for emotional commitments to other people, which suggests that the capacity for emotional commitment is not a basic psychological good (Varga, 2015, 192). He also claims that some people in the Deaf community would not say that normal auditory perception is a basic psychological good and so not everyone would agree that the capacity to communicate is a basic psychological good (Varga, 2017, 6; 2015, 193).

Let us first deal with the Deafness example, as that is the easiest to reject. Varga says that those people in the Deaf community who do not value normal auditory perception shows that the ability to communicate is not a basic psychological good (Varga, 2017, 6; 2015, 193). However, Graham does not say that normal auditory perception is a basic psychological good. Instead, Graham says that the ability to communicate is a basic psychological good. Presumably, Deaf people still value the ability to communicate, just not the ability to communicate via auditory perception. Hence, Deaf people would likely agree that communication is a basic psychological good. Contrary to Varga's claim, this is not an example in which the basic psychological goods are too narrow i.e. are not universally accepted.

[213] Varga's argument is based on Sandel, Taylor and Forst's claims that Rawls' thought experiment strips the person of a historically, culturally and communally 'situatedness' and only utilises a 'thin' concept of the self which reflects the values of political liberalism found in individualistic cultures over communitarian cultures (Varga, 2015, 191-193). While Varga does not argue that Graham's basic psychological capacities favour individualistic cultures over communitarian ones, he borrows the method to argue that the basic psychological capacities are not primary goods (see also Varga, 2017, 6).

What of Varga's claim that monks and warriors might not value having a capacity for emotional commitments to other people? Firstly, I doubt that all warriors do not value emotional commitments to others – surely some warriors fight to protect their family and tribe. Varga's point that monks might not value emotional commitments to others is slightly more plausible. While some monks value emotional commitment insofar as many monks are in the service of good of others and/or have an emotional commitment to a higher power such as God, there are some monks who do not value emotional commitment (see Wong, 2006, 208). Despite this, there are two possible ways of defeating Varga's counter example. Firstly, it might be that monks might still value the ability to emotionally commit, but choose not to exercise it. If so, then this would remain a basic psychological capacity. Secondly, it is arguable that it would be unwise to reject emotional commitment as a basic psychological good based on the relatively small population of monks. This is problematic because we would need to determine the point at which a minority view means that some capacity is not a basic psychological good. Nonetheless, it is reasonable to claim that even if some monks do not value the capacity for emotional commitment, it is still a basic psychological good.[214]

Another example that Varga might use to support his position that 'emotional commitment is not a primary good' concerns utilitarianism. Utilitarians, particularly Bentham, claim that the morally right thing to do is that which provides the greatest good for the greatest number. Having emotional commitments to one's family and friends might impede the utilitarian from carrying out those acts that would furnish the greatest good to the greatest number.[215] For example, emotional commitment might mean that a utilitarian instinctively rescues his or her own drowning child, rather than rescuing two children that he does not know (all other things being equal). On this basis, utilitarians might not agree that the capacity for emotional commitment is not a basic psychological good. However, even the staunchest of utilitarians is unlikely to hold that the capacity for emotional commitment is not a good. While utilitarians might think that the capacity for emotional commitment is not valuable in the drowning example, it is

[214] Even if the capacity for emotional commitment is not a basic psychological good, this does not render Graham's list useless. If the other basic psychological capacities are universally valued, then these may be able to determine whether a condition is a mental disorder.

[215] Here, I presume that emotional commitment is to individuals, rather than society in general. If emotional commitment were to society in general, then this example would be of no use to the idea that emotional commitment is not a primary good.

likely that even a committed utilitarian would admit that the capacity is important in other areas of life.

In a nutshell, it is difficult to come up with plausible examples in which the basic psychological capacities would not be picked by all rational agents behind the veil of ignorance. While there are possible exceptions, these are few and far between, and should not prevent the basic psychological capacities from being primary goods.

Let us now turn to Varga's claim that the basic psychological capacities are too vague. It is unclear what Varga means by 'vagueness'. Does he mean that the capacities have fuzzy boundaries, or does he mean that the capacities are too expansive? Varga says the basic psychological capacities

> are unable to *specify the type* of comprehensive, communicative and decision-making capacities that individuals need in order to lead a good life. For instance, it is not clear whether, and *at what point,* intense feelings of care and love that alter comprehension of self and the world and decision making that should count as impairment (Varga, 2015, 192, my emphasis).

The quote suggests that Varga thinks the basic psychological capacities are both too expansive and that the boundaries are too fuzzy. His claim that the point at which intense feelings that alter comprehension should count as an impairment suggests that he thinks that the problem is one of fuzzy boundaries. Varga is right that the boundaries of the basic psychological capacities are fuzzy. However, it might be that the primary goods just do have fuzzy boundaries. That is, there is no reason to presume that primary goods are discrete. Hence, the basic psychological capacities should not be rejected as primary goods just because they have fuzzy boundaries. (As Sorenson (2001) argues, many concepts are vague but are perfectly usable i.e. meaningful. Nordenfelt also points out that we can use the concept *bald* without defining precisely when a person is bald (Nordenfelt, 1997, 17-18; see section two of chapter five.) Varga's claim that the basic psychological capacities are unable to specify the type of capacities (see the above quote) suggests that he thinks the expansiveness of the basic psychological capacities is also problematic. This interpretation is backed up by Varga's point that "less vague descriptions and further specifications of the relevant psychological capacities would most probably make these too narrow, thus excluding particular ideas of the good life" (Varga, 2015, 192). For example, if the capacity for communication is narrowed to the

capacity for normal auditory perception, this will rule out some Deaf people's conception of the good life. Varga's point is that while the problem of expansiveness can be resolved by making the basic psychological capacities narrower, this will mean that the basic psychological capacities do not provide a neutral conception of the good life.

I agree with Varga's point that the basic psychological capacities cannot simply be narrowed, as this would likely rule out some conceptions of the good life. However, I disagree with Varga's claim that the capacities are too expansive to be primary goods. Primary goods might be expansive. In fact, given the diversity of values, if primary goods are to be neutral between conceptions of the good life, then they must be expansive. Hence, I disagree with Varga that Graham's basic psychological capacities are too narrow and too vague to be primary goods. They are not too narrow because they appear to include all conceptions of the good life. Even if some monks do not value the capacity for emotional commitment, it would be excessive to reject the capacity as a basic psychological good solely for this reason. Nor are the basic psychological capacities too vague – neither too fuzzy nor too expansive. While the basic psychological capacities have fuzzy boundaries, it might be the case that primary goods just do have fuzzy boundaries. In addition, the basic psychological capacities might well need to be expansive to be primary goods. In short, objections to Graham's basic psychological capacities being primary goods are not all that persuasive.

3.1.2 Do the basic psychological capacities help to determine whether a condition is a *mental disorder?*

We can now consider the second question – whether the list of basic psychological capacities will help determine whether a condition is a mental disorder. An essentialist version[216] of Graham's list of basic psychological capacities will help to determine whether a condition is a mental disorder insofar as if a condition impairs one or more of the basic psychological capacities (in a way that negatively impacts on a decent life *c.f.* flourishing life), then that condition might be a mental disorder. It is a little more difficult to use an essentialist version of Graham's list of basic psychological capacities to show that a condition is not a mental disorder. To do so, we need to make two

[216] As mentioned above, Graham develops a non-essentialist, prototypical account of *mental disorder* (Graham, 2010, 148, 165). I consider whether Graham's basic psychological capacities can be applied to an essentialist account of *mental disorder.*

presumptions. The first is that all mental disorders are disvalued because they impair a basic psychological capacity i.e. mental disorders are not disvalued for some other reason. [217] The second is that Graham's list is exhaustive of the basic psychological capacities. This can be summarised in the following syllogism:

1. All mental disorders are disvalued because they impair one or more of the basic psychological capacities (in such a way that impacts on a decent life *c.f.* a flourishing life).
2. Graham's list is exhaustive of the basic psychological capacities.
3. Impairments of basic psychological capacities are to be disvalued.
4. Condition ^{X} does not impair any of the basic psychological capacities.
5. Therefore, condition ^{X} is not to be disvalued.
6. Therefore, condition ^{X} cannot be a mental disorder.

For example, if being intelligent does not impair any of the basic psychological capacities, then intelligence is not to be disvalued. In turn, intelligence cannot be a mental disorder. Likewise, if being gay does not impair any of the basic psychological capacities, then homosexuality is not to be disvalued, and so cannot be a mental disorder. In short, an essentialist version of Graham's basic psychological capacities can show whether a condition is to be disvalued. In turn, the basic psychological capacities can help to determine whether a condition is a mental disorder.

Section 3.1.1 showed that the vagueness (fuzzy boundaries and expansiveness) of the basic psychological capacities does not prevent them from being primary goods. Nor does the vagueness (fuzzy boundaries and expansiveness) of the basic psychological capacities prevent the capacities from helping to determine whether a condition might be a mental disorder. Firstly, the expansiveness of a category does not make it difficult to determine membership. Mammal is an expansive category, but it is clear whether an animal is a mammal. Do the fuzzy boundaries of the basic psychological capacities make it difficult to determine whether a condition is a mental disorder? As mentioned above, Graham develops a non-essentialist, prototypical account of *mental disorder* (Graham, 2010, 148, 165). Prototypical accounts of *mental disorder* have fuzzy boundaries, which

[217] This presumption is reasonable given that there do not seem to be any examples in which a mental disorder is disvalued for reasons other than the impairment of the basic psychological capacities, and behaviours that stem from this.

means that it might be difficult to determine whether a condition is a mental disorder. Essentialist accounts of *mental disorder* might also have fuzzy boundaries. That is, even if an impairment of a basic psychological capacity is necessary for a condition to be a mental disorder, the basic psychological capacity might still have fuzzy boundaries which means it might not be clear whether a mental condition (i.e. an instance or a type of mental condition) is a mental disorder. For example, it might be unclear whether a person with a slightly below-average IQ has an impaired basic psychological capacity for comprehension. Equally, it might be unclear whether shyness is an impairment of the capacity for communication. It could be argued that the fuzzy boundaries of the basic psychological capacities mean that the capacities cannot help to determine whether something is a mental disorder.[218] Such an argument would be too harsh. The basic psychological capacities can still help to determine whether a condition is a mental disorder, but a condition might be a mental disorder in one society but not another.

To summarise this section, an essentialist version of Graham's basic psychological capacities can help to determine whether a condition is a mental disorder. This is not negated by the expansiveness of the basic psychological capacities. The fuzzy boundaries of the basic psychological capacities can determine the disorder-status of a condition, but as will be discussed in the following section, a condition might be a mental disorder in one society but not another.

3.1.3 Do the basic psychological capacities fix the extension of *mental disorder*?

The third question can now be considered – whether Graham's list of basic psychological capacities mean that the extension of *mental disorder* will be static over time and culture? If the basic psychological capacities are primary goods and if the extension of *mental disorder* is based on these basic psychological capacities, then in theory, the extension of *mental disorder* might be static. (Once again, I am applying the basic psychological capacities to an essentialist account of *mental disorder.*) However, Graham's approach faces two main problems. Firstly, whether a basic psychological capacity is contingent upon context. Secondly, the vagueness of the basic psychological

[218] Specifying the boundaries of *mental disorder* is a problem for everyone who considers the meaning of *mental disorder,* and it has led to the claim that *mental disorder* does not have clear boundaries (Rogers and Walker, 2017, 410; Keil and Stoeker, 2016).

capacities means that the extension of *mental disorder* might change depending on how the capacities are interpreted.

Concerning the first issue, a problem with some of the potential primary goods suggested earlier (e.g. 'being in a romantic relationship with the person you love') is that whether homosexuality impedes these goods is contingent on context. For example, whether being gay impedes being in a romantic relationship with the person you love depends on whether the gay person is in a homophobic or queer-friendly society. In a homophobic environment, being gay might impede this good, and so in homophobic environments, homosexuality is to be disvalued. Hence, the value-status of homosexuality might not be static between societies. In turn, whether homosexuality is a mental disorder might not be static between societies. Moreover, in those societies in which homosexuality is a mental disorder, it may be medically treated on this basis.

Does the same apply to the basic psychological capacities i.e. is it the case that whether a basic psychological capacity is impaired depend on the environment in which one happens to be? Take the basic psychological capacity of communication, for example. Whether a Deaf person has the ability to communicate depends on whether that person lives in a society in which sign language is widely known. In a society in which sign language is widely used (i.e. a Deaf-friendly society), then being Deaf does not impair a basic psychological capacity, and so cannot be a mental disorder (using an essentialist account). In contrast, in a society in which sign language is not widely use, being Deaf might well impair the basic psychological capacity of communication, and so might be a mental disorder. Deafness might be a mental disorder in some societies but not others. Equally, whether a person with dyslexia is able to comprehend the world (i.e. the basic psychological good of self and general comprehension) might depend on whether he or she is in a literate society. Hence, Graham's basic psychological capacities might not ensure that the extension of *mental disorder* is static between societies. If we restrict the environment to which impairment of basic psychological capacities is determined to biological environments, rather than social environments, then whether a condition impairs a basic psychological capacity is much more likely to remain static.[219] However,

[219] However, environments will change environmentally over evolutionary time periods (see, for example, Kovacs, 1998, 32-34). Hence, the basic psychological capacities will not be entirely static even if restricted to biological environments.

as Kendell points out, it is difficult to distinguish biological environments from social environments because "man is necessarily a social creature" (Kendell, 1975, 455).[220]

The second problem for claiming that the basic psychological capacities will fix the extension of *mental disorder* over time and culture is that the vagueness (both the expansiveness and the fuzzy boundaries) of the basic psychological capacities means that the extension of *mental disorder* might change depending on how the capacities are interpreted. That is, in practise, the extension of *mental disorder* might change. For example, Graham says to have the basic psychological capacity 'general self-comprehension and world-comprehension' an individual must have the ability to comprehend both ourselves and the world to the extent that enables us to live in a moderately well-informed and knowledgeable fashion. Graham does not specify what counts as a moderately well-informed and knowledgeable fashion. This is not only a problem for the fuzzy boundaries of the basic psychological capacities (the point at which a capacity is impaired). It is also a problem for the expansiveness of the capacities. The expansiveness of the capacities means that whether a society considers a person to be able to live in a moderately well-informed and knowledgeable manner might depend upon the values of the society in question. For example, in a society in which being well-educated and having a professional career are highly valued, a person with a below average IQ might be less likely to be said to be moderately well-informed and knowledgeable. In contrast, in a society in which education and professional success is not so highly valued, then a below average IQ might be more likely to be said to be moderately well-informed and knowledgeable. Hence, a person with an IQ of 80 might be said to be mentally disordered in one society but not another. While the expansiveness of the basic psychological capacities does not prevent them from helping to determine whether a condition might be a mental disorder, the expansiveness does mean that the extension of *mental disorder* is unlikely to be fixed between societies.

One of Graham's (non-essential) criteria for *mental disorder* is that the condition causes harmful or potentially harmful symptoms or consequences for the affected individual

[220] Sociobiology also complicates the distinction between biological and social environments. Sociobiology is the theory that some human behaviour can be explained in terms of genetics, instead of in terms of cultural and environmental factors. Sociobiological phenomena are biological phenomena as they are social phenomena that are grounded in biology. If we mistakenly take a sociobiological phenomenon to be purely social (or *vice versa*), then we may be mistaken about whether a condition impairs a basic psychological capacity in a biological environment.

(or perhaps others) (Graham, 2010, 165). Graham does not tell us at what point a condition is harmful. The most he says is that a harmful condition will be clinically significant (Graham, 2010, 148, 176). However, this does not help determine what is harmful, as the two are likely to inform each other. That is, I will go to a health professional when I consider a condition to be harmful, and when a condition is harmful it will be clinically significant. Once again, the lack of specificity is problematic as it might mean that a condition is a mental disorder in one society but not another. In addition, the basic psychological capacities might be inconsistent with each other and Graham does not tell us how to weigh these capacities against each other. For example, when a person has intense feelings of romantic love for another person, that person might not make reasonable decisions. In this situation, the capacity for 'care, commitment and emotional attachment and engagement' conflicts with the capacity to take responsibility for oneself (see also Thornton, 2008, 125 and Varga, 2015, 192).[221] In this way, a condition might be a mental disorder in one society but not another.

In short, Graham's list of basic psychological capacities does not fix the extension of *mental disorder* over time and culture. This is because a) whether a capacity is impaired might be dependent on the society in which one happens to be, and b) the vagueness (both the expansiveness and the fuzzy boundaries) might mean that capacities can be interpreted in different ways.[222] That is, even if Graham's basic psychological capacities are primary goods, the extension of *mental disorder* might not be static. There is a tension between the goals of a) ensuring that primary goods concerning mental states are neutral between conceptions of the good life and b) specific enough to determine whether a mental condition is to be disvalued. This tension means that it is very difficult, if not impossible, to use primary goods to provide a static extension of *mental disorder.*

Does this apply to homosexuality? That is, is it the case that homosexuality could a) impair a basic psychological capacity in a homophobic environment and/or b) does the vagueness of the basic psychological capacities means that homosexuality might be

[221] Graham notes that the weighting of the capacities may be "contextually variable" but it is the capacities themselves that interest him (Graham, 2010, 157).
[222] This may also be true for physical disorders. However, if Fulford (1993) is right that the values concerning physical states are widely agreed upon, then while the basic physical capacities (whatever they may be) may be interpreted in different ways in theory, it is unlikely that this will occur in practice.

interpreted as impairing one of these? It is, at least arguable, that in a homophobic environment, being gay impairs the basic psychological capacity of being responsible for oneself. That is, homophobic people would claim that people that are unable or unwilling to resist the urge to act on their homosexual impulses cannot control their behaviour in a reason-responsive way. The counter-argument is that gay people can control their behaviour in a reason-responsive way i.e. that being gay is within the bounds of reason-responsiveness rational in a society that is not homophobic. That it can be debated whether being gay impairs a basic psychological capacity highlights my point that Graham's basic psychological capacities are vague and open to interpretation, and in turn, that they might not fix the extension of *mental disorder* between societies. However, as argued in section 3.1.1, the basic psychological capacities cannot simply be made more specific as this would likely rule out some conceptions of the good life (see also Varga, 2015, 192). Nor can it be said that social influences, such as being in a homophobic society, should not influence whether a basic psychological capacity is impaired because, as pointed out earlier, it can sometimes be difficult to distinguish biological environments from social environments.

There is one further problem with Graham's analysis. He claims that lacking the capacity to be moral might be indicative of a mental disorder – that the 'incapacity to grasp and understand moral features of social situations and to react reason-responsively to them' might show that the basic psychological capacities of 'general self-comprehension and world-comprehension' and 'care, commitment and emotional attachment and engagement' are impaired (Graham, 2010, 174-175; see also Varga, 2017, 7). Graham thinks that those who contravene the moral code of a society might have an incapacity to understand these moral features and therefore, might be mentally disordered. He gives Ted Bundy as an example of someone whose moral behaviour could count as a mental disorder. (Ted Bundy was an American serial killer, rapist, burglar and necrophile of the 1970s.)

There are three main problems with Graham's claim that an incapacity to grasp morality might be indicative of a mental disorder. Firstly, Graham presumes, rather than shows that there is a function or capacity to grasp the moral code, and so says that an

inability to grasp the moral code is evidence of a mental disorder. [223] Secondly, it might be difficult to distinguish whether a person is incapable of grasping the moral code or disagrees with it. Thirdly, and most importantly for my purposes, in a homophobic society, a gay person might be deemed incapable of grasping morality (or, at least, incapable of grasping parts of morality) and so might be considered to be mentally disordered. More precisely, being gay could be said to be an inability to grasp the moral features (either in part or in full) of that society. In turn, homosexuality would be an impairment of a basic psychological capacity, and so might be a mental disorder.[224] In queer-friendly society, being gay would not indicate immorality, and so would not impair a basic psychological capacity and, in turn, could not be a mental disorder. Graham's claim that an incapacity to grasp morality might be indicative of a mental disorder means that the basic psychological capacities might not fix the extension of *mental disorder.*

The same applies to the other case studies considered in chapter two. In racist societies, black runaway slaves might be deemed incapable of grasping morality; in sexually conservative societies, those who masturbate might be deemed incapable of grasping morality; and in politically repressive societies, being a political dissident might be deemed incapable of grasping morality (either in part or in full). In these societies, all these people might be mentally disordered. In contrast, in societies that are not racist, sexually conservative or politically repressive, these conditions cannot be mental disorders. Hence, the basic psychological capacities do not fix the extension of *mental disorder.*

Graham does not specify which contraventions of a moral code might indicate mental disorder. He says that the concept of *mental disorder* should not be devoid of "*some* moral assessments of *some* persons and *some* behaviours" (Graham, 2010, 175, Graham's emphasis). Graham, following Churchland, seems to have in mind those acts that are universally seen as immoral, such as murder and unfairly sharing resources (Graham, 2010, 172-173). Homosexuality, masturbation, being a runaway

[223] In a similar vein, Murphy and Woolfolk say that we cannot simply claim that the capacity to learn to read is functional. Rather, we need to show that it is functional (Murphy and Woolfolk, 2000, 242-243).
[224] It could be countered that most gay people have the capacity to grasp the moral code of a society, but disagree with it. This would mean that being gay is not indicative of a mental disorder. However, as already discussed it may be difficult to determine whether a person is incapable of grasping the moral code or whether they disagree with the code.

slave or political dissident are not universally considered to be breaches of the moral code. Hence, it is unlikely that Graham would consider any of these conditions to be impairments of the basic psychological capacities. Nonetheless, unless Graham specifies which incapacities to meet the moral code might be indicative of a mental disorder, then these conditions might be deemed mental disorders in certain societies.

Graham's analysis of the basic psychological capacities is convincing insofar as it helps to determine whether a condition is a mental disorder. (It does not provide an extension of *mental disorder* that is static between societies, but this is not what Graham set out to do.) However, Graham seems to add on the idea that an incapacity to grasp morality might be indicative of a mental disorder. While Graham's claim is not novel[225], he does not give this important issue the attention it deserves. In particular, he does not consider the negative implications that it might have, such as homosexuality being indicative of a mental illness in homophobic societies. A more plausible position – the position that I take – is to be agnostic regarding whether an incapacity to grasp morality is an indicative of mental disorder. That is, Graham might be right that immorality might be indicative of a mental disorder, but a lot more work needs to be done to justify his position. Due to the abusive treatment that occurred in the name of medicine in the past (e.g. the labelling of homosexuality, masturbation, being a runaway slave and being a political dissident as mental disorders, and medically treating these conditions on this basis), we ought to tread very carefully before declaring that an incapacity to grasp morality impairs some of the basic psychological capacities, and so might be a mental disorder. Gay people, masturbators, runaway slaves, and political dissidents could all be considered to be mentally disordered even though they might simply have different views of morality and different conceptions of the good life. If Graham or anyone else persists with this line of argument, then he or she must tread extremely carefully.

4. Conclusion

Chapter five established that disvalue is a necessary component of the way *mental disorder* is ordinarily used by health professionals and informed lay-people. If a condition is not disvalued, then it cannot be a mental disorder. Chapter five also established that if the value-status of mental conditions changes over time or culture,

[225] See Schirmann, 2013, 35-36.

then the extension of *mental disorder* will also change. This chapter has considered whether the extension of *mental disorder* might be fixed by establishing if there are primary goods concerning mental states.

The chapter began with a brief explanation of the debate between moral realists and moral anti-realists. Moral realism faces the problem of epistemological access. This chapter took an agnostic stance on whether there are such things as moral truths, and instead asked whether there are any primary goods (i.e. goods that all rational agents behind the veil of ignorance would choose, regardless of their conception of the good life) concerning mental states.

Section 3.1.1 showed that Graham's (2013) list of basic psychological capacities might well be primary goods. Graham's basic psychological capacities are very basic or fundamental, and therefore are likely to be chosen by all those behind the veil of ignorance. Varga's (2015) claim that the basic psychological capacities are both too narrow and too vague to be primary goods was rejected. The capacities are not too narrow – the overwhelming majority of those behind the veil of ignorance think that one's life would be worse off without these capacities. While the capacities are vague (i.e. they are expansive and have fuzzy boundaries), this does not prevent them from being primary goods. Indeed, narrow capacities, such as the ability to learn to read, are less likely to be primary goods.

Section 3.1.2 showed that Graham's list of basic psychological capacities also helps to determine whether a condition is a mental disorder: if a condition impairs one or more of the basic psychological capacities, then that condition might be a mental disorder. Moreover, if the list of basic psychological goods is exhaustive, and a condition does not impair a basic psychological capacity, then that condition cannot be a mental disorder. The expansiveness of the basic psychological capacities does not prevent the capacities from helping to determine whether a condition might be a mental disorder. While the fuzzy boundaries of the capacities mean that there might be disagreement about whether a condition is a mental disorder, the capacities still help to determine whether a condition is a mental disorder.

However, section 3.1.3 showed that the basic psychological capacities might not provide an extension of *mental disorder* that is static over time and culture. Firstly, the

expansiveness (and fuzzy boundaries) of the capacities means that the capacities might be interpreted differently between cultures. Secondly, whether a condition impairs a basic psychological capacity might depend on environmental features of the society in question. Thirdly, Graham claims that an incapacity for morality might be indicative of an impairment to a basic psychological capacity. This means that homosexuality might be a mental disorder in homophobic societies. For these three reasons, the basic psychological capacities might not be able to determine, for once and for all, whether a condition is a mental disorder and whether it may be medically treated on this basis.

Basing the extension of *mental disorder* on primary goods regarding mental states will be a good fit with ordinary language. For example, let's say that happiness (being a mental state) is a primary good, and that having Major Depressive Disorder negatively impacts on happiness. This would mean that Major Depressive Disorder is a mental disorder, and this fits with the way *mental disorder* is ordinarily used by health professionals and informed lay-people. Moreover, as explained earlier, for a primary good to be neutral between different conceptions of the good life, it will almost always need to be very broad. This breadth means that the primary good (i.e. as Graham argues, the basic psychological capacity) might be interpreted differently in different societies. In a society that considers dyslexia to be a mental disorder (such as our literate society), the basic psychological capacity of 'self and general comprehension' (i.e. the ability to comprehend the world) might be interpreted in such a way to include dyslexia. It will fit with the ordinary language of this society. In a society that does not consider dyslexia to be a mental disorder (for example, a preliterate society), the basic psychological capacity 'self and general comprehension' might be interpreted in such a way to exclude dyslexia. This fits with the ordinary language of that society. In this way, primary goods are a good fit with ordinary language.

However, the breadth of the basic psychological capacities means that they might not provide a static extension of *mental disorder.* In turn, this approach might not exclude conditions such as homosexuality from being considered to be mental disorders. For example, if the inability to grasp morality indicates an impairment of the capacity for self and world comprehension, and homosexuality is considered immoral, then homosexuality would impair this capacity, and so would be a mental disorder in this society. In contrast, if the capacity for self and world comprehension did not include the

morality component, or homosexuality was not considered to be immoral, then homosexuality would not impair this capacity and so could not be a mental disorder. In such a society, defining *mental disorder* using primary goods might fulfil criteria 2.2 – it can show that conditions such as homosexuality are not mental disorders. However, this approach cannot fulfil criteria 2.1 – it does not provide a static extension of *mental disorder.* Graham's approach does not allow us to both have our cake and eat it. It does not fulfil both criteria 2.1 and 2.2, and in turn, it does not show that conditions such as homosexuality are not mental disorders in any society (criterion two).

Chapter Nine – Conclusion

1. Overall Findings

In the past, and in some parts of the current world, homosexuality was (or is) considered to be a mental disorder and is medically treated on this basis. As a pro-queer, rainbow waving woman, I do not support the medical treatment of homosexuality. However, the aim of this thesis was not to show that homosexuality should never be medically treated. This is because, following Earp *et. al.* (2014) (and others such as Haldeman and Bonne, see Earp *et. al.* 2014), I am open to the idea that there might be situations in which medical treatment to change an individual's sexual orientation might be acceptable. For example, if a gay person lives in a very homophobic society and gives fully informed consent to conversion therapy, then it is at least arguable that this medical treatment (i.e. conversion therapy) should be provided (see section four of chapter three). For this reason, the thesis does not consider ways in which the medical treatment of homosexuality might be prevented, but instead considers whether the medical treatment of conditions such as homosexuality can be safeguarded against by showing that homosexuality is not a mental disorder, and so may not be medically treated on the basis of being a mental disorder. It is not necessarily paradoxical to claim that 'there may be situations in which homosexuality may be medically treated' while also considering ways in which the medical treatment of homosexuality might be safeguarded against. If it is the case that 'homosexuality may not be medically treated on the basis of being a mental disorder', then the two positions are not mutually exclusive. As explained in chapter three, to claim that 'only disorders may be medically treated on the basis of being disorders' is quite different from claiming 'only disorders may be medically treated'. On the former approach, non-disorders may be medically treated, but not using the rhetoric of disorder (i.e. the pragmatic link between disorder and medical treatment). This means that, unlike the latter approach, the former approach does not rule out too much. For example, providing pain relief during child birth may be acceptable.

This line of argument (that 'only disorders may be medically treated on the basis of being mental disorders') may also be applied to masturbation, being a runaway slave and being a political dissident. That is, if these conditions are not mental disorders, then

they may be medically treated, but not on the basis of being mental disorders. In this way, the medical treatment of these conditions can be safeguarded against. Some readers might balk at this position as it allows that there might be cases in which these conditions should be medically treated. However, as will be discussed in the next section (the coda), this does not mean 'anything goes' i.e. that homosexuality and so on may be medically treated without restriction. For example, it is highly unlikely that any runaway slave or political dissident would freely consent to such treatment. Hence, this position will not, in practise, allow for the medical treatment of runaway slaves or political dissidents. It is possible that someone would consent to some treatments to curb or stop him or her from masturbating or would consent to conversion therapy to eliminate homosexuality. However, if masturbation or homosexuality is not a mental disorder, and the consenting individual is aware of this, then psychiatry is not being used as a guise for social control, and so is not problematic in this sense.

To support the claims that homosexuality, masturbation, being a runaway slave and being a political dissident may not be medically treated on the basis of being a mental disorder, two things must be established. Firstly, it must be shown that there is a link between mental disorder and medical treatment i.e. that there is such a thing as 'the rhetoric of mental disorder'. I have referred to this throughout the thesis as criterion one. Secondly, it needs to be shown that the condition in question, such as homosexuality, is not a mental disorder in any society. This second criterion has two components. Criteria 2.1 is that the extension of *mental disorder* is static between societies. Criteria 2.2 is that the condition in question, such as homosexuality, must not fall within the extension of *mental disorder.* If both parts of the second criterion are met, then the condition in question, such as homosexuality, is not, never was and never will be a mental disorder. Those societies or individuals that consider homosexuality to be a mental disorder do not just use an extension of *mental disorder* that is different to that used in the developed world, but class homosexuality incorrectly. Their extension of *mental disorder* would be wrong. Moreover, if both criteria one and two are met, then the condition in question (for example, homosexuality) may not be medically treated on the basis of being a mental disorder. A society that medically treats homosexuality on the basis that it is a mental disorder would be incorrectly applying the rhetoric of mental disorder (i.e. using the incorrect extension of *mental disorder* but correctly applied the rhetoric *c.f.* using the correct extension but incorrectly applying it). Some

societies, such as China[226], Serbia and Indonesia, still consider homosexuality to be a mental disorder, which means that in these countries, it may be medically treated on the basis of being a mental disorder. If it can be shown that these people are incorrectly applying the rhetoric of mental disorder, then we can safeguard against the medical treatment of homosexuality in these countries.

A second benefit is as follows: there exist conditions for which their status as mental disorders is debatable such as ADHD[227], schizophrenia[228] (including attenuated psychosis syndrome[229]) and Dangerous Severe Personality Disorder (DSPD).[230] It would be beneficial if criteria one and two were met, as then it could be determined, for once and for all, whether these conditions are mental disorders. In turn, it could be determined, for once and for all, whether the medical treatment of these conditions (on the basis that they are mental disorders) amounts to using psychiatry as a guise for social control. Put another way, it could be determined, for example, whether medicating children with ADHD with Ritalin can be justified using the rhetoric of mental disorder (i.e. that ADHD may be medically treated on the basis of being a mental disorder) or whether medicating children so that they can succeed in the classroom environment is a minor form of social control.

The thesis then considered whether the two criteria ('only mental disorders may be medically treated on the basis of being mental disorders' and 'homosexuality, masturbation, being a runaway slave and being a political dissident are not mental disorders in any society') were true. After defining *medical treatment* as 'those products and services, both effective and ineffective, that are provided by health professionals in their capacity as health professionals i.e. treatments that fall within the Asclepian frames', chapter four showed that there is no exclusive prescriptive link between mental disorder and medical treatment. The presence of a disorder (either mental or

[226] While homosexuality is not a mental disorder according to the Chinese Society of Psychiatrists, in practice, it is considered to be a mental disorder (Human Rights Watch, 2017).
[227] Timimi & Taylor (2004) and Conrad & Potter (2000) argue that ADHD is not a mental disorder but the consequence of expecting people to succeed in the structured environment of the classroom or office.
[228] Bentall (1993) and Boyle (1990) argue that schizophrenia is not a mental disorder because it does not meet the standards of scientific validity (Poland, 2007, 170).
[229] A diagnosis of Attenuated Psychosis Syndrome could easily be used for the purpose of social control (Gosden, 1999).
[230] DSPD was seen as a political invention that used medicine as a guise to protect the public (Gunn, 2000; see also Szasz, 2003; Buchannan, 2001; Farnham, 2001; White, 2002).

physical) is neither necessary nor sufficient to show that the condition in question should be medically treated.

While there is no exclusive prescriptive link between disorder and medical treatment, there is a pragmatic link between disorder and medical treatment. Hence, the first criterion (only mental disorders may be medically treated on the basis of being mental disorders) is true. The pragmatic link refers to the idea that mental disorders may (*c.f.* should) be medically treated because they are mental disorders. This is because both disorders and medical treatments fit within the Asclepian frame. As mental disorders may be medically treated on the basis of being mental disorders, it follows that only mental disorders may be medically treated on the basis of being mental disorders i.e. conditions that are not mental disorders may not be medically treated on the basis of being mental disorders. Hence, the first criterion is true. Some non-disorders, such as pregnancy, also fall within the Asclepian frame. This means that some non-disorders may (*c.f.* should) be medically treated. This does not jeopardise the existence of a pragmatic link between disorders and medical treatment, as the link only requires that disorder is sufficient (*c.f*. necessary) for appropriate medical treatment.

Chapters five through eight considered the second criterion (that it needs to be shown that homosexuality, masturbation, being a runaway slave and being a political dissident are not mental disorders in any society). Chapter five considered the way *mental disorder* is used in ordinary language. It acknowledged that in ordinary language, *mental disorder* might be used in multiple ways and specified that the sense of *mental disorder* that this thesis is interested in is the way *mental disorder* is used by health professionals in clinical settings and informed lay-people in serious situations. For a condition to be a *mental disorder* in this sense, it must be a) mental, b) disvalued and c) caused by a dysfunction. An advantage of basing the extension of this sense of *mental disorder* on ordinary language is that it retains the pragmatic link between mental disorder and medical treatment. A second advantage is that homosexuality and so on will not fall within the extension of *mental disorder,* at least in the developed world. That is, criterion 2.2 would be met. However, this approach does not fulfil criterion 2.1 – it does not fix the extension of *mental disorder* between societies. For example, homosexuality cannot be a mental disorder in a society in which it is not disvalued (i.e. valued or value-neutral), but might be a mental disorder in a society in which it is disvalued. Hence,

basing the extension of *mental disorder* on the way it is ordinarily used does not fulfil criterion two (homosexuality, masturbation, being a runaway slave and being a political dissident are not mental disorders in any society). In turn, it cannot safeguard against the medical treatment of these conditions on the basis that they are not mental disorders.

Chapter six considered whether science could both fix the extension of *mental disorder* and show that homosexuality, masturbation, being a runaway slave and being a political dissident are not mental disorders. This might be achieved if *mental disorder* (as used by health professionals and informed lay-people) picked out a scientifically real category (i.e. a natural kind). However, this sense of *mental disorder* cannot pick out a natural kind – neither an essentialist natural kind nor a family resemblance natural kind – because disvalue is a necessary component of this sense of *mental disorder*. However, *dysfunction* (being a component of *mental disorder*) might pick out a natural kind. Rather than contributing to the debate concerning whether *dysfunction* picks out a natural kind, this thesis considers the implications of *dysfunction* picking out a natural kind. That is, if *dysfunction* did pick out a natural kind, will it meet both criteria 2.1 and 2.2?

Chapter seven answered this question in the negative. This applies regardless of whether one is an essentialist concerning natural kinds, such as Wakefield (Wakefield, 1999a, 471-472; 2000, 36), Kripke (1980) and Putnam (1975; 1973) or a non-essentialist, such as Cooper (2005) and Dupré (1981). It also applies whether one is a conservative naturalist or a revisionist naturalist. Conservative naturalism is the position that natural kinds should be constrained by ordinary language. The benefit of conservative naturalism is that the natural kind dysfunction (presuming it exists) could not include conditions such as homosexuality, at least not in the developed world. Hence, conservative naturalism would mean that homosexuality and so on would not be included within the natural kind dysfunction (presuming it exists), at least in the developed world i.e. criterion 2.2 would be met. In addition, if *dysfunction* picked out a conservative natural kind, then the pragmatic link would be retained. This is because according to conservativism, natural kinds are constrained by ordinary language. Only those conditions that are ordinarily thought of as being caused by a dysfunction might be mental disorders. However, conservative naturalism does not fix the extension of

mental disorders. In a society that considers homosexuality to be a mental disorder, homosexuality will fall within the natural kind dysfunction (presuming it exists). This is because conservative naturalism cannot account for new scientific evidence until that evidence has been incorporated into ordinary language. Hence, conservative naturalism does not meet criterion 2.1, and therefore, it cannot meet criterion two. A conservative approach to natural kinds does not allow us to say that a society that considers a condition, such as homosexuality, to be a mental disorder is wrong, and so we cannot say that those who medically treat these conditions have incorrectly applied the rhetoric of mental disorder.

I have not shown that conservative naturalism is wrong i.e. that natural kinds should not be determined 'from the armchair'. I have only shown that conservative naturalism is problematic for my purposes because it will not provide a static extension of the natural kind in question. Nonetheless, I think there is something fundamentally wrong with conservative naturalism and refuting conservative naturalism would be an interesting area for my research in the future.

Revisionist naturalism is the position that natural kinds should not be constrained by ordinary language. Revisionist naturalism does provide a static extension of the natural kind in question – it meets criterion 2.1.[231] However, revisionist naturalism concerning the natural kind dysfunction (presuming it exists) might not exclude homosexuality and so on. In turn, homosexuality might be a mental disorder in all societies and so may be medically treated in all societies. More generally, descriptive claims about the extension of a natural kind cannot be derived from prescriptive claims about the way we want a natural kind to be. Hence, revisionist naturalism cannot safeguard against the medical treatment of conditions such as homosexuality (on the basis that they are not mental disorders). An advantage of conservative naturalism is that it retains the pragmatic link between mental disorders and medical treatment. Revisionist naturalism does not necessarily forsake the pragmatic link (see section five of chapter seven). However, revisionist naturalism might mean that the link becomes less useful. If the revisionist

[231] This applies to both essentialist and family resemblance natural kinds. However, family resemblance natural kinds may be promiscuous i.e. a single concept may pick out multiple family resemblance natural kinds. The extension of *dysfunction* might not be static between these natural kinds. I have avoided this problem by specifying that I am solely interested in the way *dysfunction* is used by health professionals and informed lay-people. This sense of *dysfunction* will not pick out multiple family resemblance natural kinds, which means that promiscuity is avoided and so will provide a static extension of *dysfunction.*

natural kind dysfunction (presuming it exists) strays from the way *dysfunction* is ordinarily used, it might be the case that all mental disorders may be medically treated and many non-disorders also may be medically treated. If so, then there would be less reason to determine the disorder-status of a condition. It might be more fruitful to determine whether the medical treatment fulfills the standard bioethical criteria or the requirements of values-based medicine (see the coda in this chapter).

In short, together, chapters six and seven show that even if *dysfunction* is a natural kind (either essentialist or family resemblance), neither conservative nor revisionist naturalism can provide an extension of *mental disorder* that applies to all societies and excludes conditions such as homosexuality. Basing the extension of *dysfunction* on a natural kind (presuming it exists) will not allow us both to have our cake and eat it – it will not meet both criteria 2.1 and 2.2, and so will not meet criterion two. In turn, the natural kind dysfunction (presuming it exists) cannot safeguard against the medical treatment of conditions such as homosexuality on the basis that they are not mental disorders. While the thesis has not succeeded in showing that both criteria 2.1 and 2.2 can be met, if *dysfunction* picks out a natural kind, then it can be shown whether a condition (such as homosexuality) is caused by a dysfunction. Even so, it cannot show that homosexuality is not caused by a dysfunction.

Chapter eight considered whether both criteria 2.1 and 2.2 could be met by considering the evaluative component of *mental disorder.* Mackie's (1977) argument from ontological queerness means that it is difficult, if not impossible, to determine whether a concept such as *mental disorder* picks out a morally real category. Hence, rather than considering moral realism, chapter eight focused on whether Rawlsian primary goods might provide an extension of *mental disorder* that meets criteria 2.1 and 2.2. It was shown that Graham's (2013) basic psychological capacities might be primary goods (*c.f.* Varga, 2015), and that primary goods might provide an extension of *mental disorder* that is a good fit with ordinary language i.e. it meets criteria 2.2. However, this approach does not provide an extension of *mental disorder* that can be applied to all societies i.e. it does not meet criterion 2.1. This is because the basic psychological capacities are so expansive that they might be interpreted in different ways in different societies. To be neutral between conceptions of the good life, the basic psychological capacities must be broad. Hence, anyone who attempted to utilise Rawlsian primary goods to fix the

extension of *mental disorder* is likely to fail. A further problem with Graham's analysis is his claim that an incapacity to grasp the moral code of a society might be indicative of a mental disorder (Graham, 2010, 174-175). This is problematic because in a society in which homosexuality is immoral, a gay person might be deemed incapable of grasping morality and so might be considered to be mentally disordered, and medically treated on this basis. The final way in which the basic psychological capacities will not provide a static extension of *mental disorder* is that whether such a capacity is impaired depends on social and/or biological features of the society in question. As criterion 2.1 is not met, conditions such as homosexuality might be considered to be mental disorders in some societies i.e. criterion two has not been fulfilled.

Overall, chapters five through eight considered three ways in which criterion two might be met, namely, by basing the extension of *mental disorder* on a) ordinary language, b) natural kinds (either essentialist or family resemblance, and conservative or revisionist), or c) values (specifically Graham's basic psychological capacities). None of these approaches have been able to show that conditions such as homosexuality are not mental disorders in any society (criterion two). It can be shown that these conditions are not mental disorders, but it cannot also be shown that these conditions are not mental disorders in any society. Equally, while it can be shown that the extension of *mental disorder* is partly static between societies (if *dysfunction* picks out a natural kind), these conditions might be mental disorders. There is an inconsistency between wanting the extension of a concept such as *mental disorder* or *dysfunction* to only include the things we want it to include, and also wanting there to be a truth concerning the extension of *mental disorder* or *dysfunction* i.e. wanting the extension of these concepts to be static between societies. We might want conditions such as homosexuality to be excluded from the true extension of *mental disorder* or *dysfunction,* but this is not necessarily the case. Further, if it is the case, this is independent from the fact that we want it to be the case. We can either base the extension of *mental disorder* on what we want to be the case or base it on the truth (presuming there is a truth). As the two might not coincide, we cannot both have our cake and eat it.

Looking at the big picture, this thesis has begun with the way that *mental disorder* is ordinarily used by health professionals and informed lay-people, and then considered whether there is a way in which the extension of *mental disorder* could be used to

safeguard against the medical treatment of conditions such as homosexuality. This cannot be done. While it has been shown that only mental disorders may be medically treated on the basis of being disorders, it has not been shown that conditions such as homosexuality are not mental disorders in any society. In other words, this thesis has not been able to show that those societies that consider conditions such as homosexuality to be mental disorders are wrong. In turn, the thesis has failed to show that the medical treatment of conditions such as homosexuality can be safeguarded against by showing that conditions such as homosexuality may not be medically treated on the basis of being mental disorders.

2. Coda

What implications does this have for the future of the debate regarding the extension of *mental disorder* and the medical treatment of conditions such as homosexuality? While this thesis has not been successful in showing that conditions such as homosexuality may not be medically treated on the basis of being mental disorders, this might not mean that the door is left open to the medical treatment of these conditions. It only means that the arguments claiming that conditions may not be medically treated cannot be based on the rhetoric of mental disorder (which necessarily includes an analysis of the extension of *mental disorder*). That is, rather than showing that the medical treatment of these conditions is inappropriate, the arguments need to show that such medical treatment is unacceptable i.e. that they should not be medically treated. Here, I claim that the medical treatment 'should' not be given, as opposed to 'may' not be given. This denotes that I am now discussing prescriptive claims concerning medical treatment. I am no longer discussing the pragmatic link between mental disorder and medical treatment.

As explained in section two of chapter three, there are at least two ways of showing that a condition (either a disorder or a non-disorder) should not be medically treated. The first is to show that, on balance, the standard bioethical criteria relevant to clinical decision-making (consent, benefit to patient, and harm-minimisation) are not in favour of medical treatment. The second is to show that the medical treatment should not be given using a values-based approach, such as Fulford's (2004a) values-based medicine (VBM). This approach claims that the values captured by the 'standard bioethical criteria' approach only pick out a small proportion of the values involved in medicine,

and to determine whether medical treatment should be given the situation that a particular patient is in needs to be considered (see section two of chapter three).

Regarding the 'standard bioethical criteria' approach, a potential argument is that in a queer-friendly society, being gay does not lead to bad outcomes which makes it difficult to maintain that conversion therapy is beneficial. Similarly, it could be shown that masturbation is not harmful in a sexually liberated society, that being a runaway slave is not harmful in societies that are not racist, and that being a political dissident is not harmful in societies that are not dictatorships. The disadvantage of this approach is that homosexuality, for example, would be considered harmful in a homophobic society. To show that being gay is not harmful in a homophobic society, it could be argued that the harm from being gay is only due to social, as opposed to biological, factors. However, distinguishing between the social and the biological can be incredibly difficult (Kendell, 1975, 455). Moreover, as Murray argues, even if harm is due to social factors, if medical treatment can alleviate the suffering of gay people living in a homophobic society, then health professionals should provide this treatment (Murray in Earp *et. al,* 2014, 9; see also Haldeman and Bonne, both in Earp *et. al,* 2014; and section four of chapter three).

Another potential reason why homosexuality should not be medically treated (on the 'standard bioethical criteria' approach) is that the medical treatment of homosexuality amounts to the homogenisation of sexuality (see Gupta, 2012) and that having a diverse range of sexual preferences is a good thing, or at least not a bad thing. Gupta says that while there are no studies that consider whether sexual diversity is a common good, there are many studies that show that racial, linguistic, and cultural diversity is a common good (Gupta, 2012, 27). That is, even if conversion therapy benefits the individual (as conversion therapy might be advantageous to a gay person in a very homophobic society), it might not be beneficial to society (or might even be harmful to society). The same can be applied to political dissidence. That is, it is good for there to be a diverse range of political persuasions and that treating people on the basis that they have a minority political view would, in turn, negatively impact on the common good. Returning to the example of homosexuality, the question becomes whether the individual (the gay person) should be denied conversion therapy for the sake of the benefit for society. In other words, should a gay person in a homophobic society be forced into martyrdom for the sake of the good of society? In addition, it is arguable that

the medical treatment of homosexuality reinforces the idea that homosexuality is a bad thing. Hence, even if I freely consent to conversion therapy to make me straight, it is arguable that conversion therapy should not be permissible because it means that other gay people who are considering conversion therapy will be more likely to seek out (and consent to) conversion therapy. As Haldeman says, "psychology cannot free people from stigma by continuing to promote or tacitly endorse conversion therapy" (Haldeman, 1994, 226). Gupta (2012) makes the same argument with respect to the claim that allowing cosmetic surgery reinforces the beauty ideal (see also Murray & Little in Earp *et al.,* 2014).[232] Once again, the question becomes whether a gay person in a homophobic society be forced into martyrdom for the sake of other gay people.

This coda has provided a brief analysis of some of the ethical arguments that could be made to safeguard against the medical treatment of homosexuality (as well as masturbation, being a runaway slave and being a political dissident). Even this short discussion has shown that these arguments are not straightforward. It seems that a knock-down argument that can show in which circumstances, if any, these conditions may be medically treated is still a long way off. Those working in the mental health field must be very careful that they are treating their clients and patients for justifiable reasons. Perhaps then, using VBM to assist with clinical decision-making – to determine whether an instance of a condition in an individual should be given a particular medical treatment – would be the most fruitful approach. According to VBM, while the patient's values have 'first call', the values of the health professionals and others "who have a legitimate interest in outcomes" are also relevant. Legitimately interested parties can include family (especially if they are responsible for the care of the patient), employers, insurers and even the State (Fulford, 2004, 81). Fulford's fundamental argument is that people's values are legitimately different, and so health professionals need to welcome a "plurality of perspectives" (Fulford, 2004, 81). By making explicit the values of all affected parties, Fulford says a better decision will be made (Fulford, 2004, 82) and also reduce the scope for psychiatry to be used for the purpose of social control (Fulford *et.al.*, 1993, 808). Whereas the 'standard bioethical criteria' approach aims to come to the 'right' answer, VBM acknowledges that values will be diverse and thus the process

[232] Haldeman, Murray and Little note the tension between the idea that providing conversion therapy or cosmetic surgery makes the health professional complicit in questionable social norms and that denying such treatments may cause the individual more suffering (Earp *et. al.,* 2014, 9).

(e.g. good communication) is more important than obtaining the 'right' outcome (Fulford, 2004a, 67; 2004b, 81-82). Rather than coming to a consensus, Fulford encourages that we come to a 'dissensus' – he does not want to homogenise diverse values (Fulford, 2004, 64). If all the relevant values of all interested parties are made clear, and disagreement is encouraged, then the chances of psychiatry being used as a guise for social control might be minimised. As Mahatma Gandhi says, 'honest disagreement is often a good sign of progress'.

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