Does Mental Illness Exist?

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1. Introduction

Nobody in their right mind would be mentally ill. This is something on which we can all agree. Some, however, have disputed whether 'mental illness' exists at all. Christopher Boorse is a philosopher well respected for his work in the debate regarding how to define concepts such as health, disease and illness. Broadly speaking, Boorse holds that disease, physical or mental, can be objectively defined as deviation from the natural functioning of the body and mind. He further holds that illness is a subset of this that refers to only serious and incapacitating diseases and that the serious and incapacitating nature of these disease can be represented by normative criteria. Whilst Boorse thinks the term 'illness' may be legitimately applied to certain cases of physical disease he argues that a parallel application of the term to certain cases of mental disease is unwarranted. This is because they cannot meet his normative conditions for illness. Boorse thus comes to the conclusion that we should not and cannot claim that 'mental illness', as the famous phrase goes, is "just like any other illness."[1]

It is a phrase that is intended to be and which I have always seen as empowering. As a result its rejection could be viewed as a serious affront to those who consider themselves sufferers of mental illness. There is, of course, one respect in which it is quite clearly the case. If we take "any other illness" as referring to serious and incapacitating diseases of the body then the conditions we call mental illnesses are unlike them purely with regards to their location. However, this is not the point Boorse wishes to make. He objects to the use of the term illness in cases of mental disease on the grounds that no mental disease can clearly meet his conditions that it is i) undesirable for its bearer, ii) an entitlement to special treatment and, iii) a valid excuse for normally criticisable behaviour. It is my intention, and the purpose of this essay, to argue that each of these three conditions can be applied with equal ease to serious and incapacitating mental diseases as they can be to serious and incapacitating physical diseases.

My essay has the following structure. I begin by considering Boorse's motivation for producing an objective, biological account of disease. The arguments he gives in favour of taking such an account, I suggest, are not

1 Boorse, *Disease and Illness,* p. 66

quite as strong as he thinks. However, I accept that an account of disease should be given in objective and scientific terms. I then explain Boorse's account of disease as deviation from statistically normal functioning. This account I argue is not tenable because of problems relating to the size of the reference classes from which we take what is statistically normal. Following Jerome Wakefield, I go on to offer an account of disease, very much in the spirit of Boorse's original, that avoids the problems of a statistical account. This is disease as a mechanism's deviation from the functioning for which it was naturally selected. I accept, provisionally, Boorse's analysis of illness as disease that meets the three normative conditions previously mentioned. Though they both accept its existence, neither Boorse nor Wakefield give a very full account of what mental disease actually consists of. As such I offer an analysis of mental disease that is in keeping with both of their accounts of disease in general. I argue that for each of Boorse conditions for illness, serious and incapacitating mental disease is capable of meeting them at least as clearly as serious and incapacitating physical disease. I further argue that Boorse's conditions fail to allow as illness some (physical) diseases our intuition would strongly suggest it should. This is a problem with Boorse's analysis of illness. I will conclude that the term illness can be applied just as automatically to certain mental diseases as it can be to certain physical disease and as such mental illness does exist.

2. Defining Disease and Illness

i) Objectivism vs Constructivism: Boorse's Motivation

Philosophers involved in the debate around how to define terms such as disease and health can generally be put into one of two camps, objectivism or constructivism. Both objectivists and constructivists about disease tend to hold that both empirical judgements about human biology and normative judgements about human well-being play a role in helping us decide what we label disease.[2] The two positions are characterised by which of these two different types of judgement are given primacy when it comes to deciding whether a condition is a disease. Those who endorse objectivism argue that what constitutes both health and disease are biological facts about normal human functioning. This normal functioning is something from which the

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2 Murphy, *Concepts of Disease and Health*

organs and collections of organs that perform it can depart. Objectivists further hold that for such a departure from normal functioning to be a disease involves a normative judgement that departing from abnormal functioning is bad.[3] [4] Constructivists on the other hand, whilst not denying that the different disease labels we use refer to specific biological processes, believe that normative judgements have primacy in deciding what is and isn't a disease. They argue that no set of biological malfunctions can be identified as the causes of certain diseases.[5] Rather we decide that a condition is a disease by judging that it causes harm to the person affected by it. What we consider harm tends to be set by some cultural conception of what human nature is, where harm is the failure to meet the culturally set standards of how a human should behave and operate.[6] Proponents of constructivism hold that once we have made the normative judgement that a condition is harmful we then identify the biological processes that are responsible for that condition. What is important is that there is no way of objectively stating that a person's body is deviating from biologically set natural functioning. Rather we make a normative judgement that a condition is harmful and what we consider harmful is determined by whether it deviates from socially or culturally defined norms. The biology then explains the causes of this condition but is not dysfunctional in and of itself.

Christopher Boorse has been positioned by Dominic Murphy as the philosopher offering what is perhaps the most plainly stated objectivist account of disease.[7] Boorse's terminology, however, differs quite substantially from that used in the generalised description of the position I have just given. In Boorse's account the term disease is defined in a way that makes no reference to normative judgements about whether the condition is harmful. Therefore Boorse holds that a disease is a deviation from biologically normal human functioning and this deviation can be either harmful or beneficial. His account reflects objectivism's secondary criteria, that the condition is something judged to be harmful or bad, by introducing to the debate the term 'illness'.

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3 Murphy, *Concepts of Disease and Health*

4 It should be noted that this is not the form that Christopher Boorse's own objectivist account takes. His differs in a number of different ways, as I will explain later on.

5 Murphy, *Concepts of Disease and Health*

6 Murphy, *Concepts of Disease and Health*

7 Murphy, *Concepts of Disease and Health*

Thus, on Boorse's account, a disease is any deviation from a human's natural functioning and a disease is an illness based on normative judgements we make about it. This means that what counts as a disease is much broader for Boorse than for other objectivists because the secondary normative judgements about the value of a condition are not involved in determining its status as a disease. A disease can be harmful *or* it can be beneficial. How this can be will become clearer as we look more closely at Boorse's account. Still Boorse's account gives primacy to biologically set deviations from natural human functioning and uses normative judgements about the value of this deviation in deciding whether or not it is an illness. Boorse's usage of 'disease' might seem odd or confusing because it is far broader than the normal folk usage of the term. He uses it not only to refer to cancerous growths, infections and birth defects but all of the different kinds of injuries and causes of death.[8] This means things like cuts and bruises fall under 'disease' as he uses it, along with a whole host of other conditions to which we would be unlikely to apply the term in everyday talk. Some examples he gives include seasickness, gunshot wounds, extra body parts, electrocution and drowning.[9] In defence of this broad use of the term Boorse points to the fact that these are all things listed as diseases in the American Medical Association's *Nomenclature*.[10] It is a standard medical use of the term, even if it isn't the common use of the term.

In his paper *On the Distinction between Disease and Illness,* Boorse puts forward his influential and, at first sight, convincing account. Of paramount importance to Boorse is that his account of disease should be value-free, he writes, "the idea of health ought to be analyzed by reference to physiological medicine alone."[11] In offering an account of disease free from value judgements, Boorse is responding to writers who have sought to explain the meaning of words such as 'health', 'unhealthiness' and 'disease' as evaluative normative terms. Such writers are constructivists about disease. Boorse identifies two positions within the constructivist camp; strong and weak normativists. Those who take a strong normative approach to defining these

8 Boorse, *Health*, p. 550

9 Boorse, *Health*, p. 551

10 Boorse, *Health*, p. 551

11 Boorse, *Disease and Illness,* pp. 49-50

terms (Boorse cites Dr. Judd Marmor as one example[12]), have argued that calling a condition unhealthy is just to express disapproval of it[13]; to say that it is bad or undesirable. Others, expressing views in line with a weaker normativism, argue that whilst calling something unhealthy or a disease involves some descriptive property relating to the nature of the condition it also necessarily involves a normative value judgement that it is bad or undesirable.[14] Similarly calling a condition healthy, whilst descriptive in some sense, must involve a value judgement that it is good or desirable. It is probably an oversight on Boorse's part that the way in which he describes the position held by constructivism's weak normativists could equally well be attributed to most objectivists as defined earlier. They too hold that disease involves some descriptive property, normally that some part of an organism is dysfunctional, and a value judgement, that it is harmful or something similar. It is important that the weak normativist gives priority to the judgement that a condition is harmful or beneficial before looking for its biological cause. Objectivists look first for biological dysfunction. Normative judgements come second. The problems that Boorse sees as inherent in constructivist accounts of disease he offers as motivating factors for accepting his alternative, objectivist account.

Boorse's objections to the normative accounts take the following form. Proponents of strong normativism about disease state that in calling a condition this all we are doing is making a judgement about its value and that judgement is that it is bad. He claims that strong normativists argue that for a condition to be a disease it is *necessary* and *sufficient* that it is bad.[15] Yet it is clear this is not how we use the term. There are countless examples of things that we consider bad and conditions we find it undesirable to be in that are not diseases. To be ugly is bad and undesirable but being ugly is not a disease.[16] The human need to sleep might be seen as undesirable, you could get a lot more done if it didn't exist, but this is not a disease either.[17] Furthermore, many conditions treated by medical physicians are undesirable. Plastic surgeons will make your large nose smaller and better proportioned.

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12 Boorse, *Disease and Illness,* p. 51

13 Boorse, *Disease and Illness,* p. 51

14 Boorse, *Disease and Illness,* p. 52

15 Boorse, *Disease and Illness,* p. 52

16 Boorse, *Disease and Illness,* p. 52

17 Boorse, *Health*, p. 544

On women they will perform procedures to increase or decrease breast size. Doctors regularly terminate unwanted pregnancies. For the most part undesirable physical features or undesired pregnancies are not diseases.[18] As such a condition being 'bad' cannot be sufficient for it to be a disease. Given these counter examples from Boorse, it appears to be undeniably the case that a condition being judged bad is not sufficient for to be a disease. The wealth of conditions people have or might find themselves affected by, which we judge to be bad, and yet are quite clearly not diseases, makes being a strong normativist an impossible position to defend.[19] Boorse is certainly right to reject this position as he does. Yet such obvious failings makes one call into question why and whether anybody holds this view in the first place and this in turn makes one question whether the problems with the strong normativist position are quite the motivating force for accepting his alternative account that he believes they are. As mentioned before, the example of a proponent of strong normativism given by Boorse is that of Dr. Judd Marmor who, in his paper *Homosexuality and Cultural Value Systems*, Boorse quotes as saying:

> "to call homosexuality the result of disturbed sexual development really says nothing other than that you disapprove of the outcome of that development."[20]

Boorse believes we can substitute the term "disturbed" here for 'unhealthy' or 'diseased' and thus ascribes the view to Marmor that to call a condition unhealthy is "only to express disapproval of it[21]", to judge that it is bad. Neither Marmor's original claim nor the claim as it is after Boorse modifies it to

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18 Boorse, *Disease and Illness,* p. 52

19 Boorse criticises the strong normative position for labelling as disease conditions, such as unwanted pregnancy, that we would not in everyday talk call diseases. However, as I will explain in greater detail later on, Boorse himself uses disease to refer to things like shaving cuts and gunshot wounds. Neither of which we would standardly describe as diseases. Murphy (Stanford Encyclopedia of Philosophy) draws a distinction between revisionist and conservative approaches to defining disease, where the conservative view says our theory of health should be constrained by our folk understanding of the term and the revisionists hold that we should change our concept of disease to fit whatever new conditions the theory that we settle on might include. Boorse attacks strong normativism on conservative ground whilst appearing to be revisionist himself. He might be able to justify this though, since as I have explained his use of term disease, whilst odd, is in accordance with the AMA's *Nomenclature.*

20 Boorse, *Disease and Illness,* p. 51

21 Boorse, *Disease and Illness,* p. 52

fit his purposes are equivalent to saying that judging something to be bad is sufficient for it to be a disease. To begin with, Marmor uses the phrase "says nothing other than" to express the relationship between calling something the result of disturbed sexual development and you expressing disapproval of it. This may well be true, but it does not follow that expressing disapproval of something says nothing more than you calling it the result of disturbed sexual development. This is because expressing disapproval of something is ambiguous and could take many forms, whilst calling something the result of disturbed sexual development is just one very specific way of disapproving of something. It is not true to suggest that Marmor is claiming that expressing disapproval of something is sufficient for it to be called the result of disturbed sexual development. There are many ways in which one can express disapproval where this is not the case. Further, if we follow Boorse and read Marmor as saying 'to call something a disease says nothing other than you judge it to be bad', it still does not follow that something being judged bad is sufficient for it to be a disease. The term bad is ambiguous. So whilst calling something a disease may say nothing other than it is something you judge to be bad the reverse is not true. If I judge a friend's new T-shirt bad I do not say nothing other than it is diseased. Calling something a disease may well be nothing other than a way of judging that it is bad, but judging a thing bad can say something other than that you are calling it a disease. This is because the relation expressed by 'nothing other than' is not one that is necessarily symmetrical. For it is quite clearly the case that it could be true that Larry has no other friend than Jeff and yet also be true that Jeff has some other friends than Larry. Finally, Boorse refashions Marmor's original assertion into the claim that to call a condition unhealthy is 'only' to express disapproval of it. This is a claim about necessary conditions which means that if it is true that you have called a condition unhealthy it is also necessarily true that you are expressing disapproval of it. However, it does not follow from it being necessary that you disapprove of something in order to call it unhealthy that your disapproval of something is sufficient for it to be unhealthy. Boorse therefore makes a false inference when he suggests that Marmor's claim, about the relationship between calling something the result of disturbed sexual development and expressing disapproval of it, is equivalent to the sufficiency claim between something being judged bad and being a disease that he so strongly objects to. By making false inferences about Marmor's claims and offering objections to a position it is not clear that anybody actually

holds, as motivation for the rejection of the constructivist approach to defining disease and acceptance of his alternative approach, Boorse's arguments fail to provide the motivating force he had hoped they would.

Those in favour of weak normativism, the other constructivist view-point Boorse identifies, downgrade being bad from being sufficient for a condition to be a disease to being merely necessary and in doing this might hope to avoid the problems faced by the stronger version. However, Boorse argues convincingly that this is not the case. There are many conditions that are diseases and yet are also desirable. Famously, it was discovered that by contracting the disease of cowpox humans could build immunity to the much more serious, often fatal, disease of smallpox. Thus, in a world where smallpox had not yet been eradicated suffering the condition of cowpox would be desirable.[22] The are also cases where diseases are neither desirable or undesirable. Boorse offers infertility as an example of one such disease. Some might suggest that diseases considered desirable in certain cases are at least prima facie undesirable, meaning they would be undesirable if considered apart from any special set of circumstances.[23] Boorse believes that this is not the case and cites the disease of infertility in support of this. To say that infertility is prima facie undesirable relies on the assumption that most people want to reproduce and to find this out would require an empirical survey of human preference on the matter.[24] No such surveys seem to have taken place in human physiological research.[25] The disease of infertility is only undesirable in the special circumstances of someone wanting to have children and only desirable in the special circumstances not wanting to have children, but having unprotected sex.[26] Prima facie it is neither desirable or undesirable.

There is no denial from Boorse that it is generally true that health is something we value whilst disease and unhealthiness are things we tend not

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22 Boorse, *Health*, p. 545

23 Boorse, *Disease and Illness,* p. 53

24 Boorse, *Disease and Illness,* p. 53

25 Boorse, *Disease and Illness,* p. 53

26 I have some doubts as to whether infertility is really a disease on our folk understanding of the term as opposed to being a just symptom or result of a disease. Boorse is being revisionist but as we have seen has criticised others on conservative grounds. Nevertheless, one can imagine a disease whose only effect was infertility and this would work just as well in his example.

to value. However, by highlighting the fact that certain diseases are desired and many undesirable conditions are not diseases, Boorse wishes to show that it is not value that defines these terms. He draws a parallel with intelligence which, whilst undeniably valued by the majority of people, can be stated as the ability for a person to perform certain intellectual tasks.[27] Whether or not a person is capable of performing these tasks can be settled without reference to their value. Boorse believes the same can be said of human health and thus develops his objectivist account, placing objective biological facts about normal human functioning at the forefront of his definition of health and explaining disease as deviation from this functioning.

ii) Boorse's Objectivist Account

How then does Boorse characterise the normal functioning from which disease deviates? He begins with an explanation of medical normality given by C Daly King that normal should be defined as that "which functions in accordance with its design".[28] It is clear that there is a certain biological design common to all members of a specific reference class in a species (where reference classes are natural groups based on factors such as age and sex). For Boorse what is normal is what is natural for a member of a species, and what is natural for a member of a species is the functional design shown to be typical of the organisms that falls within that member's reference class.[29] What is an organisms function? Boorse defines something's function as its contribution to a goal.[30] For most man made objects the goal they aim towards is set by their creators. A chair's goal is to support the weight of the body of a sitting person and a chair functions normally as long as it does this. Once the chair breaks, and human body it was intended to support is left lying on the ground, some part of the chair is no longer making a contribution to its goal. The chair is dysfunctional. We can uncover the goals of organisms by looking at evolutionary theory. As environments change over time so too do the things living in them. They adapt in ways that allow them to achieve a constant goal or set of goals. For Boorse the goals that all organisms are directed towards

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27 Boorse, *Disease and Illness,* p. 54

28 Boorse, *Disease and Illness,* p. 57

29 Boorse, *Health*, p. 555

30 Boorse, *Health*, p. 555

are reproduction and survival.[31] [32] We can identify these goals (empirically, via observation of organisms across different environments and over time) and how organisms function to accomplish them (through scientific investigation) without any reference to the value of their pursuit.[33] These are higher-level goals at the apex of all behaviour by organisms. Lower down the hierarchy of goals individual elements of the body are directed towards achieving more specific ones. In humans, certain cells are directed towards goals of metabolism and mitosis.[34] Specific organs too have specific goals. The kidneys, for example, are goal-directed towards the purification of a persons' blood. The contribution of each element of an organism towards it goals is further a contribution to the goals that reside at the top of the hierarchy,[35] reproduction and survival. The biological functional design of any given part of a living thing is to perform its contribution towards the overall goals of the organism.

This is not the end of the story though. The contribution that an organism's biological functions make towards the goals of survival and reproduction need to be typical contributions within a reference class,[36] be it for a whole species, a particular sex or a certain age group. This is to eliminate the problem that some characteristic of an organism might contribute to survival or reproduction in a way that isn't actually its function. Boorse gives the example of a squirrel having its life saved by its tail getting caught in crack, causing it to narrowly avoid becoming roadkill.[37] This does not mean that the function of the squirrel's tail is to protect its owner from being hit by a car. Similarly it does not mean that any squirrel's tail that fails to get caught in a crack en route to being hit by a car is dysfunctional. The function of any given characteristic of an organism is the *typical* contribution it makes to the survival or reproductive success of the organisms within its reference class. Preventing a squirrel from being hit by a car is not the typical contribution the tail makes to that species' survival, the contribution is an anomaly, it is accidental. How does Boorse think we should decide what is the typical

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31 Boorse, *Health*, p. 556
32 Boorse, *Disease and Illness,* p. 57
33 Boorse, *Disease and Illness,* p. 58
34 Boorse, *Disease and Illness,* p. 57
35 Boorse, *Health*, p. 556
36 Boorse, *Health*, p. 556
37 Boorse, *Health*, p. 557

contribution of an organism's characteristic to its goals? He argues that it is a statistical notion, much like the composite picture of the an organism given in educational textbooks. What a textbook provides is a portrait of species design, where each detail of the composite organism is statistically normal according to an average taken across a reference class of organisms.[38] So whilst no person may ever be found that matches this portrait precisely, because almost everyone suffers disease and so will be atypical in some sense, it is nevertheless the case that such portraits represent the species design and provide a good reference by which to judge health and lack of it. To be complete, Boorse's notion of statistical functional normality in organisms needs also to account for functional traits that can differ from one member of a species to another whilst still being perfect healthy. O positive may be statistically the most common blood type and brown statistically the most common eye colour but not having either of these traits doesn't mean your blood or eyes are dysfunctional or unhealthy. Boorse suggest these can be incorporated into species design disjunctively by saying it is typical of human blood to be one of the different types and typical of irises to be one of the many colours.[39] Skin colour too should be incorporated this way, it is typical of human skin to have some degree of pigmentation [40], this is why black skin and white skin are statistically normal and part of the species design whereas albinism (a completely lack of pigmentation) is a dysfunction and a disease. Other human characteristics that should be incorporated disjunctively include height, weight and body shape; only individuals that fall outside of the statistically normal range should be classified as dysfunctional. A disjunctive approach cannot deal with differences between the sexes or different age groups where people are still perfectly healthy, it appears species design is relative to both these things.[41] Thus we deal with these by looking for what is typical for specific small reference classes rather than an entire species.[42] It would be typical for those within the reference class of human males to have the male reproductive organs, and this would be healthy and normal functioning, even if it were statistically average for members of the species Homo sapiens to be female.

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38 Boorse, *Health*, p. 557
39 Boorse, *Health*, p. 558
40 Boorse, *Health*, p. 558
41 Boorse, *Health*, p. 558
42 Boorse, *Health*, p. 558

Given what has been said we can summarise Boorse's account of disease as follows: A disease is a condition that causes an organism to deviate to some extent from the typical functioning performed by the members of a reference class within a species. Where an organism's functions are to be understood as its individual parts' and processes' contributions to the goals of reproduction and survival and where a typical functioning is to be understood as a that which is statistically average for members of a specific references class. Typical function and deviation from it can be stated without reference to value of health or disease. There is one final caveat, which Boorse adds to deal with the problem of universal disease. A condition like tooth decay affects almost every human being and as such is problematic, because it would appear statistically that it constitutes typical functioning for a member of the species. This would mean we might have to say it is incorrect to call tooth decay a disease and this is not the kind of revision Boorse wishes to make. To cope with this he examines what is actually being said by calling disease statistically atypical functioning, concluding that in essence one is calling it 'unnatural' because it deviates from natural functional design of the organism.[43] In calling tooth decay a disease we are also saying that it is unnatural, that it is not part of the natural design of the organism, but this cannot be because it is statistically atypical. Tooth decay is unnatural, Boorse suggests, because it can be attributed to the effects of a hostile environment [44] rather than being part of the species design. It is therefore a disease. A disease is an unnatural condition that either consists of deviation from statistically typical functioning or can be attributed to the hostile environment in which the organism lives. For Boorse if it meets one of these criteria then it is a disease, regardless of the value we place on it.

iii) Towards a better Account

The account presented by Boorse does a very convincing job of arguing that what is a disease can be decided objectively and not in terms of normative judgements about a conditions value. That said, there is a major problem with this account that needs to be addressed. As we have seen, on Boorse's account, a disease is a deviation in an organism from the typical functioning

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43 Boorse, *Disease and Illness,* p. 59

44 Boorse, *Disease and Illness,* p. 59

performed by members of a reference class. We have also seen that this reference class cannot just be all members of that organism's species as this would turn too many perfectly healthy conditions into diseases. Boorse noticed that what constitutes typical functioning for the elderly is very different (and much broader) than that for the young. Even more different is the typical functioning of the individual sexes. Thus, reference classes seem best divided not only along lines of species, but by age and sex as well. However, we actually need to go further than this. The typical functioning of a reference class that denotes a group of organisms of the same species, sex and age will still have deviating from it people who are perfectly healthy and not in any way diseased. Rachel Cooper highlights this in her paper *Disease*. She notes that certain races (Masai) are more sensitive to growth hormones that others [45] and yet this is still healthy for them. Athletes tend to have lower heart rates than the majority of people, a deviation from typical functioning, but they too should not be called diseased, in fact they are in the best of physical health.[46] Furthermore, people who live at high altitudes, or any in number of different environments, often adapt to suit their habitats [47] and this can involve deviation from the typical functioning of other organisms of the same species, sex and age as them. This does not make them unhealthy or diseased though. Were they not to deviate, their prospects for survival could be seriously reduced. Thus it becomes clear that any reference class is going to have to be far more fine grained to avoid the incorrect labelling of healthy people as diseased.[48] This might seem all well and good but when we start talking about reference classes as fine grained as female 20-something South African professional swimmers who have grown up in the Yorkshire Moors it becomes immensely plausible that this reference class will only contain one person. If the reference class contains only one person whatever happens to them will be typical functioning for that reference class.[49] There can be no deviation and, therefore, no disease. There will be no way of distinguishing an accidental contribution to the individual survival from a body part's natural functioning.[50] If our swimmer catches her hair on a tree branch and this stops her from absentmindedly walking off a cliff then this will be the

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45 Cooper, *Disease*, p. 266
46 Cooper, *Disease*, p. 266
47 Cooper, *Disease*, p. 266
48 Cooper, *Disease*, p. 266
49 Cooper, *Disease*, p. 266
50 Cooper, *Disease*, p. 266

hair's typical functional contribution to the goal of survival for member of her reference class. This is clearly not right. Even if the reference class consists of a few more members (three or four, for example) then the probability of the same accidental contribution happening to all of them is much higher than it would be in a reference class drawn along lines of species, sex and age. As such conclusions drawn about typical functioning could become inaccurate.[51] It is not possible to ascribe a minimum number on the amount of people a reference class denotes as, not only would this have to be arbitrary, it would also continue to wrongly classify as diseased some healthy people who happen to have unique functional contributions to the goals of survival and reproduction. It seems we have to reject Boorse's account because of its reliance on statistical deviance.

Jerome Wakefield suggests that to avoid such a problem one might try and drop the requirement that disease is deviation from *statistically* typical functioning and instead argue that it is a relative functional disadvantage in pursuing the goals of survival and reproduction.[52] This means that disease would consist of deviation from objectively set optimal functioning. The issue with such an approach is that there being just a few people with exceptionally high functioning in one part of their body would, therefore, mean everybody who functioned less than optimally is diseased.[53] It would mean almost everyone is diseased. Wakefield agrees with Cooper that Boorse's account of disease will have to be rejected, but he does believe that Boorse is right to invoke ideas of evolutionary set design and function in offering a biologically objective account of disease.[54] He disagrees not only with Boorse's use of statistical deviation in classifying disease but also with the use of reproduction and survival as the functional end goals of an organism. Whilst any organisms' mechanisms were originally selected for their functional contribution to these goals, a failure to increase survival and reproduction in a modern environment does not necessarily suggest dysfunction.[55] Wakefield thus develops his own account of disease and dysfunction which I believe stays true to the essence of Boorse's, whilst avoiding the issues relating to

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51 Cooper, *Disease*, p. 266
52 Wakefield, *Mental Disorder*, p. 379
53 Wakefield, *Mental Disorder*, p. 379
54 Wakefield, *Mental Disorder*, p. 379
55 Wakefield, *Mental Disorder*, p. 379

invoking statistically typical functioning and deviance from it.

In developing his account Wakefield uses the term 'disorder' as opposed to 'disease'. This is perhaps more clear than Boorse's unusual use of 'disease'. Nevertheless, to avoid confusion I intend to use Boorse's terminology throughout. Furthermore, Wakefield, an objectivist like Boorse, incorporates a normative component under the term disorder defining it as "Harmful Dysfunction" where harm is judged by the standards of a person's culture.[56] I will only take from Wakefield his account of dysfunction which I believe is a successful (in that it avoids Cooper's objections) alternative to Boorse characterisation of dysfunction as deviation from statistically typical functioning. I shall follow Boorse in introducing the normative component separately under the term illness. I believe it will strengthen my objections to Boorse's conclusions about mental illness if I stay true to the terminology and structure of his account of disease and illness.

So, we have seen that Boorse defines disease as dysfunction where this consists of deviation from statistically typical functioning or a condition that can be attributed to a hostile environment. Such a characterisation of dysfunction will not work because of the problems relating to the size of the reference classes on which we base our analysis of what is statistically normal. I suggest Wakefield's account of dysfunction as one that avoids such problems. Wakefield summarises a condition that is dysfunctional (and thus would, on Boorse's account, amount to a disease) as the following: one that "results from the inability of some internal mechanism to perform its natural function, wherein a natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mechanism."[57] Dysfunction, or deviation from functioning, is thereby the failure of some mechanism within an organism to fulfil its natural function. But natural function cannot be, as Boorse argues, just what is statistically typical for a member of that organism's reference class. Also we need to be able to distinguish which effects of a mechanism are its natural function or functions and which are not. The heart has the effect of pumping blood around the body and also of making a regular beating sound.[58] Only the pumping of blood is its natural function,

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56 Wakefield, *Mental Disorder*, p. 384
57 Wakefield, *Mental Disorder*, p. 384
58 Wakefield, *Mental Disorder*, p. 382

but what makes it so? Wakefield, like Boorse, highlights the connection between something's function and its design; the function of an artefact is the purpose for which it was designed.[59] Thus the function of an artefact has great explanatory value. It explains why the thing was made, i.e. to perform a specific job, and it explains why the artefact is structured in a particular way and operates in a particular way.[60] We can, for example, explain a number things about a washing machine, including its existence and why it has been built as it has, simply by pointing to its function of washing clothes. With functional explanations an objects effect, such as washing clothes, can be understood as explaining the thing itself. This is odd because it is the basic principle of causality that cause must preceded effect. It seems as though functional explanations violate this principle.[61] Wakefield argues, however, that function can enter into an explanation of an object if "there is some additional theory that shows that the cited effect plays some role in the events that preceded the artefact's creation."[62] In the case of man-made objects it is clear that the effect comes before the artefact that will later cause it, in that it was in the mind of the person who designed the object. Therefore a functional explanation is a fuller causal explanation; an artefact exists because a person desired a certain effect and believed that in creating this artefact they would be able to achieve this effect.[63] The belief and the desire about the effect of the artefact caused it to be created. The artefact then causes that effect.

Wakefield argues that we can give similar function explanations of natural mechanisms, despite the fact they don't have a designer. Natural functions explain certain organs and mechanisms, one can answer the question "Why do hearts exist?" by saying "because they pump blood around the body".[64] "Why does the heart have its particular structure?" "Because this allows it to pump blood around the body." The natural function of an organ or mechanism in an organism is the effect it has that explains it existence, structure and activity.[65] Responding to the question "why do hearts exist?' by saying "because they make a sound" is not to answer it, because this is not the heart's natural

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59 Wakefield, *Mental Disorder*, p. 382
60 Wakefield, *Mental Disorder*, p. 382
61 Wakefield, *Mental Disorder*, p. 382
62 Wakefield, *Mental Disorder*, p. 382
63 Wakefield, *Mental Disorder*, p. 382
64 Wakefield, *Mental Disorder*, p. 383
65 Wakefield, *Mental Disorder*, p. 383

function. Furthermore, evolutionary theory shows us that a natural mechanism's effects can explain both its existence and its structure. If a mechanism effects an organism in such a way that it contributes to its reproductive success, then over time it is naturally selected and this explains why it exists today. Functional explanations of natural mechanisms, like functional explanations of artefacts, are thus causal explanations given in terms of natural selection.[66] A mechanism is selected because it provides a certain effect, this effect explains why it was selected and therefore explains the existence of the mechanism. The mechanism then causes that effect. We are now left with the following account of dysfunction. A natural function is the effect of a mechanism within an organism that explains the existence, structure and activity of that mechanism; the function for which it was naturally selected. A dysfunction is the inability of the mechanism to perform this function. This is an account of dysfunction that avoids the problem of stating it in terms of deviation from statistically typical functioning, as Boorse attempted to do. For Boorse disease is, in essence, deviation from natural functioning, i.e. dysfunction. If we incorporate Wakefield's account of dysfunction into Boorse's account of disease then we are left with an account that does not fall foul of Cooper's objection, whilst still remaining true to the spirt of Boorse's original and retaining the objectivist's non-reliance on value judgements.

iv) Illness

Boorse has given an account of disease in terms of biological fact about the natural functional design of an organism. Whether a condition is a disease is to be decided based on these biological facts alone with no reference to the value of the condition. Thus a sixth sense [67] or an extra finger might be of great value to a person who gains important knowledge from chatting to the dead or is able to pull off intricate piano pieces with ease, but it remains a disease simply because it is not statistically typical functioning for organisms of their type. On our improved account it is a disease because it deviates from natural functioning, where this is explained by evolution (though it is possible that in the future it could be given an evolutionary functional explanation and, thus, would no longer be a disease). As I have said,

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66 Wakefield, *Mental Disorder*, p. 383

67 Boorse, *Disease and Illness,* p. 60

objectivist accounts of disease do tend to involve normative judgements about the value of a condition as a secondary criteria. Boorse introduces this normative component under the term 'illness'.

Illness, Boorse argues, is a subclass of disease that takes into account normative judgements about the value of a condition.[68] Essentially illnesses are diseases that are serious enough to be incapacitating and, therefore, judged undesirable.[69] As such they involve a negative judgement about their value.[70] While the disease covers the whole range of conditions that constitute a deviation from typical biological functioning, from a small cut on the finger to pancreatic cancer, illness takes this and adds further evaluative criteria that the condition must meet. In his article *On the Distinction between Disease and Illness* Boorse places emphasis on disease needing to be "reasonably serious [71]" and to have "incapacitating effects [72]" in order to be an illness. It is these features of illness he believes are reflected in a disease's undesirability. He appears to offer shaving cuts [73] and mild athlete's foot as examples of diseases that are neither serious or incapacitating enough to make then undesirable and, therefore, illnesses.[74] This does not seem quite right. These are both things that are undesirable despite their relative triviality and lack of any real incapacitating effect. Nobody wakes up desiring a shaving cut, nor do they enter into the grooming procedure not caring either way. Shaving cuts are something we actively avoid, something we don't want, and it think this is reflected in the razor's evolving design, with more and more features being added to eliminate the possibility. Athletes foot too, however mild, I'm sure is something those suffering it would happily describe as undesirable. I think Boorse is wrong to suggest only a disease that is serious

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68 Boorse, *Disease and Illness,* p. 56

69 Boorse, *Disease and Illness,* p. 56

70 Boorse, *Disease and Illness,* p. 61

71 Boorse, *Disease and Illness,* p. 56

72 Boorse, *Disease and Illness,* p. 56

73 It was not immediately obvious to me how, on Boorse's account, a shaving cut would count as a disease. It would seem that, providing the skin healed properly, then it was performing its functional contribution to the goals of survival and reproduction. However, it is one of the major functions of the skin to provide a barrier against the invasion of pathogens and a cut breaks this barrier giving germs direct access to the blood (Proksch, Brandner & Jensen 1063). I remain unconvinced that the ability to bear and heal wounds does not constitute natural functioning for the organ but I think that Boorse may have grounds for asserting that a shaving cut is an interference with the skin function and, therefore, a disease.

74 Boorse, *Disease and Illness,* p. 56

and incapacitating is undesirable. Being slightly unpleasant or mildly annoying is enough. Nevertheless a disease does seem to need to be serious and incapacitating for it to be an illness and whilst undesirability alone does not reflect these things I believe the other conditions Boorse proposes in his analysis of illness do.

The three conditions given by Boorse as necessary for a disease to be an illness are as follows:[75]

(i) that it is undesirable for bearer
(ii) that it entitles them to special treatment
(iii) that it is a valid excuse for normally criticisable behaviour

The first condition better explains what Boorse means when he calls an illness a disease that has been judged undesirable. It must be the diseased person him/herself that judges it so. Imagine the six fingered man is troubled by his additional appendage. Perhaps it doesn't work as well as his other fingers and quite often aches to the point that it causes him distress. Maybe it means he can never be a hand model like his father, and his father before him, as well as costing him a fortune in bespoke gloves. This would make the disease undesirable for its bearer and, if it met the further two conditions, might plausibly be considered an illness. If the extra finger causes him no bother but has been judged undesirable by his mother who doesn't want the neighbours to see it then it would not be fair or correct to call it an illness. The judgement that it is undesirable must come from the person affected by the disease.

Second is the condition that for a disease to be an illness it must entitle the bearer to special treatment. Boorse does not elucidate much on what 'special treatment' consists of although he does talk about the 'sick role [76]' as a kind of special position people take. Everybody can have some small amount of disease, and it is probable that everybody does, but to be ill the disease has to be above and beyond what most people have. Therefore people who are ill are in a special position and thus entitled to special treatment. So we can attempt to find out what Boorse means by 'special treatment' by looking at the

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75 Boorse, *Disease and Illness,* p. 61

76 Boorse, *Disease and Illness,* p. 65

kind of treatment we give to people in the sick role. A non-exhaustive list might include professional medical attention, intervention and care, time off work and other responsibilities, benefits and financial support, perhaps concern from others. A person will not be entitled to this kind of treatment unless they suffer a disease that is both reasonably serious and incapacitating and therefore an illness. This condition, along with the undesirability one, does a better job than just undesirability alone of reflecting the requirement that, for a disease to be an illness, it needs to be serious and incapacitating in some sense.

The third condition looks to be related in someway to the second. Behaviours like taking time of work or not being involved in caring for your children for a period of time are normally criticisable but when a disease is serious and incapacitating then it does provide a valid excuse for these behaviours. Boorse suggests there is a connection between illness and diminished responsibility.[77] Illness applies to physiological diseases and thus, Boorse argues, the relation between a person and their illness follows the same model as the relationship between a person and their body.[78] He notes that it has been often argued that the physiological processes our body performs do not count as our actions, nor does it count as our action when they go wrong, which means we are not responsible for them.[79] Of course, not all diseases that are serious and incapacitating will cause a person to behave in a way that is normally criticisable. However, If they do and the root of this behaviour can be traced back to a physiological disease, a process which is not our action and therefore we are not responsible for, then this would provide a valid excuse for the behaviour.

Boorse believes that these three conditions provide a plausible analysis of illness as disease that meets further normative criteria. As support for his analysis he points to the fact that it can explain why the notion of, and term, illness is not one we apply indiscriminately to all living things. Here he is referring to plants and animals.[80] However, due to our tendency to anthropomorphise animals ("Look, she's sad, awww", "Buster has got a

77 Boorse, *Disease and Illness,* p. 61
78 Boorse, *Disease and Illness,* p. 62
79 Boorse, *Disease and Illness,* p. 62
80 Boorse, *Disease and Illness,* p. 56

girlfriend") I think the point works best when we just consider plants. We call plants diseased when they have something like fireblight or white rot because these constitute a deviation from typical functioning for that type of organism. We do not call plants ill. This is because we cannot make the appropriate normative judgements about plants, nor can they make them about themselves.[81] A plant is not responsible for its actions, it cannot even act, thus we cannot judge that it has diminished moral responsibility for its behaviour. Also, plants have no desires and as such cannot judge a disease that affects them to be undesirable. Whilst I am undecided as to whether non-human animals have desires, it is certainly true that they cannot be held morally accountable for their behaviour. Boorse argues that even when they die we do not say that they suffered an illness.[82] He may well be right, but the situation is confused because we so often treat animals as if they are humans.

3. The Case Against Mental Illness

Boorse does not deny that one can have a mental condition that is, using his terminology, a mental disease. He assumes that there are such things as natural mental functions [83], which seems fair. The mind is certainly structured in a way that makes it possible for us to achieve certain goals. It seems to have a number of faculties, for memory, reasoning, imagining, processing sense data etc., all of which interact with each other in certain ways and perform different functions. For Boorse the majority of recognised mental diseases [84] would constitute an unnatural interference with, or deviation from, these mental functions.[85] On his original account this would be functioning that deviates from what is statistically typical for a member of the person's reference class. On our improved theory of disease this would be the failure of a mental mechanism to perform the natural function for which it was selected. Wakefield suggests we know that certain mental mechanisms,

81 Boorse, *Disease and Illness,* p. 56

82 Boorse, *Disease and Illness,* p. 56

83 Boorse, *Disease and Illness,* p. 62

84 Boorse actually uses the term 'disorder' to make this point and continues to use this term interchangeably with disease throughout his essay. This is a little confusing as he is quite defiantly using both terms to mean the same thing and, whilst it is beyond the scope of this work to enter into such a debate, it is certainly plausible that the two terms could be given differing definitions. I will stick with 'disease'.

85 Boorse, *Disease and Illness,* p. 62

cognitive, perceptual, affective and so on, have been selected over generation of humans because of the evolutionary benefit they provide[86] and have effects that justify their existence. If their effect, or function, is not being performed then this is dysfunction, and therefore, a disease the same as bodily disease. The mechanism for fear response, for example, has the function of helping a person avoid danger, when they are in it. Failure to perform this properly would would be a dysfunction. So conditions like agoraphobia, heliophobia (fear of the sun) and mysophobia (fear of germs) would all be a mental disease.[87]

Neither Boorse nor Wakefield offer a very full account of what kinds of dysfunctions mental disease actually consists of. Boorse simply assumes that there are mental mechanisms that can deviate from their statistically typical functioning. Wakefield admits the difficulty when it comes to mental disease of discovering the function for which mental mechanisms were naturally selected given our current state of ignorance about the specific workings of the mind.[88] I suggest that mental mechanisms can dysfunction in two different ways thus resulting in mental disease. The first of these involves a dysfunction with a person's mechanism for the production of beliefs. One of the main functions of some of our beliefs and mental systems that produce them seems to be to track the truth. Holding true beliefs about the world around us, when combined with the motivating force of desire, allows us to interact with it in meaningful ways. Our beliefs that certain things are dangerous, when they are in reality a threat to us, combined with the desire to escape danger allows us to respond with appropriate behaviour when we are under threat. This has obvious evolutionary benefit. Similarly having other beliefs that track the truth can aid us in our evolutionary goals of survival and reproduction. True beliefs about things like being followed and, more broadly, that a certain action will produce/result in a certain end provide evolutionary benefits. We can thus, following Wakefield, presume that one of the functions for which the mental mechanisms involved in the production of beliefs were naturally selected for was their ability to track the truth.

86 Wakefield, *Mental Disorder*, p. 383
87 Wakefield, *Mental Disorder*, p. 383
88 Wakefield, *Mental Disorder*, p. 383

Regarding Boorse's understanding of disease [89] I think we could quite safely assume that it is statistically typical to hold true beliefs about certain relevant things.[90] On this account we can now understand certain mental diseases as involving dysfunction on the belief end of the belief-desire mechanism that produces behaviour. If we take the example of heliophobia I gave earlier we can see how this works. Heliophobia is a person's fear of the sun. The mental mechanism that produces beliefs about things that present a threat to us has been naturally selected to perform the function of providing us with true beliefs about these threats. In people affected by heliophobia this mechanism is dysfunctional in that it has produced a false belief relating to the level of threat the sun poses towards that person. This is why it is a mental disease. The desires that motivate a person to behave as they do (staying indoors, only going outside at night) is not faulty as this is a perfectly rational behaviour to engage in given the false belief that the sufferer holds.

Depression, bipolar-disorder, schizophrenia and some types of obsessive compulsive disorder all involve, I would say, some kind of dysfunction in the mechanism for producing beliefs. A recent television documentary, *Sectioned*, followed several people committed to a Nottingham psychiatric hospital.[91] A patient called Richard who was shown in the film had been diagnosed as having paranoid schizophrenia. Richard held plans to kill himself on Christmas day, endure a brief spell in hell, before beginning his training to become, eventually, the King of England. We can understand the dysfunction that constitutes Richard's mental disease as the failure of his belief-producing mechanism to produce beliefs that track the truth when it comes to reasoning. Part of the functioning for which our belief producing mechanism was naturally selected is to produce true, or at least approximately true, beliefs that performing a certain action will lead to certain end. In Richard's case this belief-producing mechanism is clearly dysfunctional. Richard's desire to be King of England, and his desire kill himself, I would not say are dysfunctional given his beliefs that, a) it is possible for him to become King (which seems a

89 I am not here endorsing, or returning to, Boorse's account. I merely wish to highlight that, were we to put aside the objections to his account, this analysis of mental disease would still work for him.

90 I say relevant because their are some false beliefs that it might be statistically typical to hold, such as the belief that Humphrey Bogart said "Play it again, Sam" in the film *Casablanca*. Holding beliefs of this kind is not relevant to survival and has no real effect on our understanding of the world and other people.

91 BBC4, *Sectioned*, 19 May 2010

fairly reasonable thing to desire) and, b) by killing himself on Christmas day he will achieve this goal.

The examples given so far are mental diseases because they involve the belief-producing mental mechanism failing to perform its function of producing, in certain situation, beliefs that track the truth. These are beliefs about things posing a threat to a person and beliefs involved in reason that a certain action will achieve a certain end. Depression too involves a dysfunction in the belief-producing mental mechanism but the beliefs that it is failing to correctly produce serve a different purpose. It has been suggested that there is a phenomenon known as depressive-realism where by depressed people are more likely to give accurate judgements about future events and themselves.[92] So if the only function of the belief-producing mental mechanism was to produce beliefs that track the truth then depression would not involve a dysfunction at all. It seems likely to me that a further function of the belief-producing mental mechanism is, when it comes to beliefs about the self, to produce beliefs that bolster a person's feelings of self-worth, self-importance and well-being. It has been convincingly argued by writers such as Shelly Taylor and Jonathon Brown that self-deception and positive illusions about one's own worth and control are evolutionarily advantageous in situations of adversity.[93] Given this evidence we can see that one of the functions for which the belief-producing mental mechanism was naturally selected is to produce positive beliefs about one's own self-worth. It is also fair to assume that it is statistically typical that this mental mechanism functions in this way. Thus depression is a mental disease because it involves a dysfunction in the belief-producing mental mechanism's ability to produce positive beliefs about the self. The desires commonly associated with depression are of withdrawal from society and pleasurable activities and of killing oneself.[94] Once again we can see that these are not dysfunctional given the affected person's beliefs about their self-worth, self-importance and right to live and enjoy life.

The second way in which mental mechanisms can dysfunction, resulting in mental disease, does involve desires. It has been argued that there is a

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92 Ackermann & DeRubeis, *Depressive Realism*, pp. 565-6

93 Taylor & Brown, *Illusion and Well-Being*, p. 201

94 APA, *DSM-IV-TR*, pp. 375-376

hierarchical structure to human desires. We have first-order desires which are just desires about things, such as the desire to eat, drink, smoke, exercise etc. Positioned above these are further higher-order desires. These are desires about our desires. So whilst we have the desire to eat when we're hungry, we also desire that we should have the desire to eat when we are hungry. It seems a plausible analysis to me that the natural function of the mental mechanism for the production of desires is to produce first and higher order desires that are in sync. When a person's first-order desires match their higher-order ones then they provide the proper motivating force in the production of action. When the two levels do not match the result is psychological turmoil, which is counter-productive. I would like to suggest that one of the functions for which the desire-producing mechanism was naturally selected, beyond simply making things that motivate action, is to produce higher and first order desire that match each other. I would also suggest that it is statistically typical that people's first-order desires are in sync with the higher-order ones, so this can further fit with Boorse original account. A dysfunction in desire-producing mechanism's ability to create synchronised first and higher-order desires can nicely explain certain mental disease not explained by a dysfunction in the belief-producing mechanism. Drug and alcohol addiction are things we might consider to be mental diseases. They are certainly considered so by some. If we take drug addiction as an example then this involves the affected person having an immensely powerful first-order desire for a certain substance. In most cases I would say it also involves that person having a higher-order desire that they should not desire to take their chosen poison. It is thus a mental disease because the mechanism that produces first and higher order desires has malfunctioned and failed to produce desire that match up to each other. I suspect there might be room to deny that drug and alcohol addictions are really mental diseases given the physical dependancy they can cause. Perhaps a clearer case is Trichotillomania, often regarded as a form of OCD,[95] which is characterised by the compulsive urge for a person to pull out their hair. This involves the person having a first-order desire to pluck out strands of their hair but a higher-order desire not to desire to do this. There is thus a dysfunction with the mental mechanism that produces these desires and it is a mental disease.

95 It is sometimes refereed to as an Obsessive Compulsive Spectrum Disorder. Others include compulsive skin picking, hoarding and hypochondria.

I have given an account of the dysfunction involved in mental disease but, whilst mental disease exists, Boorse does not think it is right to further talk of mental illness in the same way we talk about bodily disease and bodily illness.[96] He holds this view because he believes that that a mental disease cannot meet the three normative conditions for illness that I discussed earlier. In this section I will explain why he holds this and argue against his conclusions.

i) Undesirability

On Boorse's account, the first condition a disease must meet for it to be an illness is that it is undesirable for its bearer. Boorse does not believe this is possible in cases of disease of the mind. It is obvious that when one asks if a condition is undesirable for the person affected by it then they must make the judgement of whether or not it is by looking at that person's desires. Desires, Boorse assumes, perform a motiving role or function in the production of a person's action [97] (along with beliefs). In the context of mental health, Boorse argues, it could be the persons desires that we have judged diseased in the first place.[98] This, it seems, will inevitably raise problematic issues. We judge desires to be diseased because they do not conform to the species design.[99] For Boorse this would be the case if they were statistically atypical for a person in a particular reference class. Less problematically they do not conform to species design if they fail to perform the function for which evolution has naturally selected them. What Boorse believes is that it is not clear why we should desire our desires to conform to this design. He writes, "the desirability of having species-typical desires is not nearly so obvious on inspection as the desirability of having species-typical physiological functions.[100]" If our diseased desires are not undesirable then they are not an illness. To illustrate this Boorse uses the example of homosexuality.[101] Boorse's account of disease strongly suggests that homosexuality should be considered one. In homosexuals sexual desire does not, it would appear,

96 Boorse, *Disease and Illness,* p. 62
97 Boorse, *Disease and Illness,* p. 63
98 Boorse, *Disease and Illness,* p. 63
99 Boorse, *Disease and Illness,* p. 63
100 Boorse, *Disease and Illness,* p. 63
101 Boorse, *Disease and Illness,* p. 63

function towards achieving the top goal of reproduction. It is also statistically atypical. But, Boorse argues, even if homosexuality is a disease there is no reason to assume that it is undesirable. The desire for heterosexual sex might be statistically normal but the only reason Boorse can think of for wanting this desire is that it would make is bearer happier. The problem is that this assertion needs to be supported with evidence [102].

Discussions about homosexuality and mental illness are often uncomfortable ones. The *American Psychiatric Association* listed homosexuality in the Diagnostic and Statistical Manual of Mental Disorders (commonly known as just the D.S.M.) up until 1973.[103] Generally speaking people in most cultures would not agree with this classification and I suspect that facts like this are behind a lot of the suspicion people feel towards the label of 'mental illness'. That Boorse even calls homosexuality a disease might be abhorrent to some due to its negative connotations, but we should remind ourselves of broad sense in which he uses the term. He suggests that health, for him biological normality, is only instrumentally good instead of being intrinsically good.[104] This means that heterosexual sexual desire is good because it leads to reproduction and the survival of the parent's genes, it is not good in and of itself. It is worth noting that on our Wakefield inspired new account of disease as dysfunction there is good reason to claim that homosexuality is not disease in the first place and, therefore, cannot be an illness. If one can give a functional explanation of why the mechanism that produces sexual desire for member of the same-sex has been naturally selected, then homosexuality would not be a disease.[105] A number of proposals have been made that suggest just this. One suggestion is that homosexuality can indirectly improve an individual's reproductive success by allowing them to rise to the top of social hierarchies where they can get more access to members of the opposite sex.[106] Another suggestion is that homosexuality survives through kin selection because it benefits groups of relatives. Gay males in Samoa apparently devote more time to their nieces and nephews.[107] Such evolutionary explanations might seem cold and unromantic, in the case of the

102 Boorse, *Disease and Illness,* p. 63

103 Cooper, *What is wrong with the DSM?*, pp. 1-2

104 Boorse, *Disease and Illness,* p. 63

105 Cooper, *Disease*, p. 269

106 Le Page, *Evolution myths*

107 Le Page, *Evolution myths*

first one perhaps even offensive, but breaking things down scientifically and biologically does have a tendency to do this. Something as beautiful as a baby deer looses its appeal when dissected. Of course these are only proposals. Whilst it seems unlikely that cases of homosexuality would so persistently reoccur if they did not confer some evolutionary benefit there may plausibly come a time where we have to bite the bullet and concede that same-sex sexual desires are a disease. Thus, Boorse's point would be in this case that in order to call these desires an illness needs much more evidence to justify it.[108] In comparison he believes the desirability of good health (species typical physiological functioning) and undesirability of serious and incapacitating physical diseases are far more obvious. "We must be clear that requests to justify the value of health in other terms are always in order, and there are reasons to expect that such justification will require more evidence in the psychological domain than in the physiological."[109]

It appears that Boorse is arguing that when it comes to mental diseases, because it is often a person's desires that are faulty, it becomes much harder to justify the desirability of them being any other way. He demonstrates this with the example of homosexuality which he sees as diseased sexual desire because the desire is not performing the species typical functional contribution to the goals of survival and reproduction. We don't call homosexuality an illness, Boorse argues, because there is no real reason to claim the species typical desire for the opposite sex is more or less desirable for the bearer than the non-species typical one. I agree with Boorse that it is not clear that having same-sex desires are either desirable or undesirable. However, in the case of homosexuality there is a good reason why any undesirability is not clear. Boorse has designed his undesirability condition to reflect the fact that an illness is a disease that is both serious and incapacitating. If same-sex sexual desire is a disease (and it probably isn't) then it is still neither of these two things. Never have I heard of anyone incapacitated by gayness; having to stay home all day because they have come down with a case of same-sex attraction or unable to socialise because they are going through an intense period of homosexuality. There are reasons that people struggle with these desires but there is nothing serious or incapacitating having the desires in and of themselves. It is not obviously undesirable because it is not incapacitating.

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108 Boorse, *Disease and Illness,* p. 63
109 Boorse, *Disease and Illness,* p. 63

It is not an illness because it is not incapacitating. Conversely, a mental disease like depression is undesirable because it is incapacitating. Disabling sadness when it is a normal, healthy reaction to events that happen in your life has got, I would argue, undesirability built into it. When this sadness is the result of a disease then it doesn't stop being undesirable. Boorse argues that in cases of mental disease we need more evidence that they are undesirable than in cases of physical disease because it is a person's desires that are under scrutiny for being faulty in the first place. From my analysis of depression we can see that this is simply not the case. It is beliefs that are faulty and the belief-producing mechanism that is dysfunctional. A depressed person's desires function healthily. As such we have no reason to question the undesirability of this incapacitating disease.

Still, there are some mental diseases that do involve a dysfunction in the desire-producing mental mechanism. Certain types of Obsessive Compulsive Disorder might be best understood this way. OCD could perhaps be best understood as a collection of mental diseases displaying similar behavioural symptoms (i.e. compulsive behaviours) involving a dysfunction in either the mental mechanism for the production of beliefs or the mental mechanism for the production of desires. The disease is characterised by recurrent intrusive thoughts, images and impulses generally not related to real life problems. These in turn lead the affected person to perform repetitive physical and/or mental acts in response in order to reduce distress or prevent some imagined terrible event from occurring. These actions (things like hand washing, counting, checking etc.) are either an excessive response to the thing they are trying to prevent or completely unrelated.[110] For someone to be diagnosed as having OCD the condition must cause them clear distress, be time consuming or interfere significantly with that person's life academically, occupationally, socially or all three.[111] If it is not properly treated most patients are significantly disabled.[112] Many cases only involves a dysfunction in the belief-producing mechanism. There are, for example, cases of OCD where, to avoid something awful happening, a person engages in repetitive behaviour seemingly unrelated to the event they fear (washing your hands to stop your family getting hit by a truck, counting to twelve to avoid getting murdered).

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110 Jenike, *Obsessive Compulsive Disorder*, p. 260

111 Jenike, *Obsessive Compulsive Disorder*, p. 260

112 Jenike, *Obsessive Compulsive Disorder*, p. 260

These cases involve a dysfunction in the belief-producing mental mechanism meaning it fails to produce beliefs that track the truth about a) the level of threat posed to that person or their loved ones and, b) that a certain action will achieve a certain end.[113] Here the disease is undesirable because it is incapacitating, often incredibly so. Also, the desire to perform the action, given the false belief, is not dysfunctional so we have no reason to question the reliability of the sufferer's judgment that it is undesirable. Other cases of OCD do involve, like Trichotillomania, a dysfunction in the desire-production mechanism. These are the forms of the disease where the person affected feels compelled to perform a certain action just because it feels right. Things like flipping a light switch a certain number of times, touching bollards as you walk past and taking a step back for every two steps forward as you climb a staircase are all examples of obsessive compulsive behaviours that might be performed in the absence of any worries about the consequences of them not being performed or any beliefs about what performing them will achieve. I suggest this is a dysfunction whereby the desire-producing mental mechanism is producing first-order desires to perform these compulsive actions that clash with that persons higher-order desires about their first-order ones. This results in distress. This assertion can be supported by looking at a phrase often used to describe the behaviours associated with OCD; 'ego-dystonic'.[114] This phrases means that they are behaviours that are in conflict with that person's image of him/herself and this nicely sums up the relationship between clashing first and higher-order desires. Whilst the desire-producing mental mechanism is dysfunctional here it is the higher-order desires that we consult when judging that something is undesirable for its bearer and in these types of OCD the higher-order desires remain rational. For this reason we can legitimately say that whilst the persons first-order desires are faulty, because they are not in sync with the higher-order ones, we have no reason to doubt the sufferers judgement that their disease is undesirable because it is on the basis of perfectly rational higher-order desires that this judgement is made. I see no need for further evidence to justify the undesirability of OCD for its bearer.

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113 This is not the only way an OCD suffer's belief-producing mental mechanism can go wrong. I have developed, along these lines, a number of very plausible analyses of the many different forms OCD can take but have had to leave these out due to the constraints of a word limit.

114 Freeston et al., *Self-Report*, p. 29

Depression and Obsessive Compulsive Disorder are both mental diseases that are undesirable for their bearers. If they meet Boorse's other two conditions, and I will argue that they do, then we have at least two things that on Boorse's own account can be labelled mental illness as automatically as we would label a physical disease as physical illness. There are, however, a number of other mental diseases that we commonly label mental illnesses about which Boorse might have legitimate cause to argue are not undesirable for their bearer. In Stephen Fry's 2006 documentary about bipolar disorder *The Secret Life of The Manic Depressive,* Fry asked a number of people affected by the disease whether they would, if they could, push a button to make it go away. All but one of his interviewees said they wouldn't. Bipolar disorder is characterised by extreme elevated moods, the manic part, and really miserable lows, the depressive part. One man, an ex-navel officer, who said he would not press the button told Fry "If you've walked with angels, all the pain and suffering is really worthwhile."[115] Of course Stephen Fry's findings are not scientific or conclusive. Psychiatrists Diana Chan and Lester Sierling have written specifically about the documentary saying it stands in contrast to the finding of studies that report the majority of people with bipolar disorder claim it has a profoundly negative effect on the quality of their life.[116] Nevertheless it does seem to lend some credence to the view that, for certain mental diseases at least, healthy mental functioning is not as clearly something to be desired as healthy physical functioning.

The problem, as is demonstrated in the Stephen Fry example, is that in the case of certain mental diseases, it does seem that they are not so clearly undesirable as serious and incapacitating physical diseases. If we think about these cases though, I think it will become clear that the disease is in fact quite obviously undesirable. I do not believe that any one of the people interviewed by Fry would deny that their bipolarity was serious, incapacitating and at least prima facie undesirable. Unless they had a particularly sadistic streak then I think we can also safely assume that none of them would wish their mental disease on another person. The fact of the matter is that to live with a disease so serious and incapacitating means it becomes a major defining feature of your life. It is tied up inextricably with that persons self image. It explains many of their choices and actions. To suddenly remove something

115 BBC2, *Stephen Fry*, 19 September 2006

116 Chan & Sireling, *I want to be 'bipolar'*, p. 103

that has had such a massive effect on a person's life raises worries about whether they would be the same person at all or have the same identity. This also the case with some physical diseases. The disease of blindness is a dysfunction that is undeniably serious, incapacitating and prima facie undesirable. Despite this there are a fair number of blind people who, given the option, claim that they would not wish to be able to see.[117] The reason, I think, is the same. For such people having no sight becomes a defining characteristic, part of their personality, to be able to see would change this immensely. The vast majority of serious mental disease are as clearly undesirable for the bearer as serious physical disease. Where this is not so clear there are also parallel cases relating to serious physical disease. There are further reasons to doubt that the undesirability of serious and incapacitating physical disease is so immediately clear. Both Rachel Cooper and R B Jones talk of a South American tribe who almost universally developed a condition called dyschromic spirochaetosis. The condition was valued by the tribe for the coloured spots that it produced on their skin,[118] so much so that those who did not develop it were unable to attract partners.[119] It is also apparently the case that the disease tended to lead to their deaths.[120] There is very little more serious or incapacitating to a person than their demise and it was the disease of dyschromic spirochaetosis that caused it for many members of this tribe. For these reason I think we should call it an illness, yet it remains hugely desirable for some of its bearers. These examples show the problems of subjective evaluation when it comes to judging the desirability of both physical and mental diseases; simply put, people desire all kinds of odd things. Human beings are massively prone to self deception and will change their desires and beliefs to put the best spin on whatever situation they find themselves in. It may well be that if given the ability to see or relived of the disease of manic depression a blind person and a bipolar person respectively would actually decide they are much better off. Boorse has designed his three conditions to reflect the serious and incapacitating nature of disease we would call illnesses. However, his undesirability condition fails to capture even some physical diseases that are both these things. This is a problem for his account; to allow that these

117 The same is also true of some deaf people. Jackie Leach Scully is a deaf academic who has written on this matter.

118 Cooper, *Disease*, p. 273

119 Jones, *Impairment, disability and handicap*, p. 377

120 Cooper, *Disease*, p. 273

diseases are illnesses we would have to say that they ought to be undesirable. Thus for Boorse's account to accept them as illnesses we will have to turn towards something more objective. I suggest that the notion of a disease being incapacitating can do a better job of deciding objectively when a disease is an illness than the notion of undesirability Boorse hoped would reflect this. We call a disease incapacitating when it, in some respect and in a non-trivial way, make us unable to perform the everyday tasks we should otherwise be capable of. The problem with this is that it is unclear at which point a disease that inconveniences a person becomes one that incapacitates them. It is only once we decide what is incapacitating that we can decide what counts as an illness.

It is a proposal from John Harris that I think can help settle this matter. Harris puts forward a number of interesting ideas in his attempts to define 'disability'. I think, with some adaptation, these can be appropriated to help us decide objectively whether a disease incapacitates someone such that we would call it an illness. In his article *Is Gene Therapy a Form of Eugenics?* Harris suggests that a condition is a disability if we considered a mother-to-be who knew about the presence of the condition in her unborn child and was able to take preventative steps against them being born with it, but did not take these steps, to be deliberately harming or handicapping her child.[121] Harris further talks of something being a disability if a doctor who was aware of the condition and able to treat it would be considered negligent if they failed to do so in a patient unable to communicate their preferences [122] (i.e. they were unconscious or unborn). I suggest that a disease (where disease is deviation from the natural functioning of some physical or mental mechanism) is objectively incapacitating if we would consider negligent a doctor responsible for the care of an unborn child who knew about and was able to treat that disease but failed to do so. We now have no problem in saying why the examples of physical disease that troubled Boorse's account are illnesses. A doctor who identified the disease of either blindness or dyschromic spirochaetosis in an unborn child and was able to treat this but did not would be considered negligent (and the mother who did not allow them to treat it would be actively handicapping her child). The two physical diseases are therefore incapacitating. Now what of mental disease? Imagine that an

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121 Harris, *Gene Therapy,* p. 167

122 Harris, *Gene Therapy,* p. 166

unborn child could be identified as having a mental disease like bipolar disorder, schizophrenia, OCD, depression or even a major phobia. Now further imagine that the doctor responsible for its care could with relative ease, and without any threat to the child, eradicate this disease. Would we consider that doctor negligent if they did not do so? Knowing the impact, the pain, suffering and misery these diseases can impose on a persons life we certainly would. As such these mental disease are just as clearly incapacitating as the physical ones and as equally deserving of the label 'illness'. We might now reintroduce the notion of undesirability in a more objective way by having it map the fact of incapacitation.

ii) Special Treatment

The second condition for a disease to be an illness is that it should entitle the person who is affected by it to special treatment. Boorse rightly observes that in order to be entitled to special treatment one has to be in the minority. If this were not the case then the treatment wouldn't be special. Everyone can be a little diseased without actually being ill, it is only very serious and very incapacitating diseases that are illnesses.[123] Boorse states that when it comes to mental health "psychiatrists suggest the stronger thesis that it is statistically normal to be significantly incapacitated by neurosis."[124] The term 'neurosis' here is archaic word for a collection of the conditions we call, Boorse thinks illegitimately, 'mental illnesses'. It is distinct from 'psychosis' which covers mental diseases that involve things like hallucination and delusions. It is conditions like OCD, depression, chronic anxiety and phobias, where the patient is still in most regards in touch with reality, that 'neurosis' covers. In his footnotes he quotes a figure from Dr. Reuben Fine that claims neurosis afflicts 99 percent of the population. As Boorse has argued something cannot be an illness unless not everybody is ill; it is a special role. He believes this means people with mental diseases cannot be legitimately described as being ill because the majority of people are affected by them. Whilst we do regularly bestow special treatment upon those people deemed 'mentally ill', Boorse does not seem to think this appropriate. One apparent outcome of this is, that on his account of disease as that which deviates from statistically typical functioning for an organism within its reference class, if everyone is

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123 Boorse, *Disease and Illness,* p. 65

124 Boorse, *Disease and Illness,* p. 65

significantly incapacitated by neurosis it would not count as a mental disease either. I don't think this is what Boorse wishes to say, which is another reason for adopting the improved account of disease I have offered.

Regardless, to argue that it is statistically normal to be significantly incapacitated by neurosis is deeply flawed. Even if this is the case it is quite easy to see that there are a certain minority of people even more significantly incapacitated, sometimes entirely. It is these people who are mentally ill. They are entitled to special treatment because of the abnormal extent to which they are affected. Whilst it is plausible, though not proven, that everyone suffers quite a lot from things like worry and anxiety there are a few for whom this is atypically intense. On our improved account of disease we can explain anxiety in terms of the survival benefits it provides in identifying and being aware of threats to ourselves and our kin. The mental mechanism for the production of beliefs has the function of producing beliefs about the danger of certain situations that track the truth about the threat they actually pose. When it gets to the point that a person is afraid to leave their house, or step on the cracks in the pavement, then this mechanism is not functioning in accordance with the reason for which it was naturally selected. It is a dysfunction and therefore a mental disease. According the mental health charity *Mind* the figure for people in Britain suffering mental health problems is between one in six and one in four.[125] The figures are similar in other parts of the world. The United States organisation *The National Institutes of Mental Health* estimates that around one in four adults suffer a mental disorder (a mental disease in Boorse's terms). They further estimate that only about 6% of the population, or one in seventeen people, suffer the burden of illness.[126] As I have said, it is possible for 99 percent of the population to suffer a mental disease and for it to still, in certain cases, be an illness. These are the cases in which it is serious and incapacitating, thus entitles its bearer to special treatment, and not everybody suffers a mental disease like this. On both Boorse's account and our improved version tooth decay is recognised as a disease. Boorse has stated that tooth decay is an almost universal disease and as such we would not classify it as an illness(because it is not an entitlement to *special* treatment). There must, however, come a point for some people where tooth decay becomes so serious and incapacitating that it

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125 Hatloy, *Mental Distress*

126 NIMH, *The Numbers Count*

is an illness when judged against Boorse's own conditions. When a person's mouth is visibly rotten, it stinks, is a constant source of pain, and the teeth begin to fall out then this will meet all Boorse's conditions - undesirable, deserving of special treatment and if there is an criticisable behaviour relating directly to the condition it will be an excuse for it. Despite the fact it is a disease universally suffered there is a level at which it becomes serious enough and incapacitating such that it is an illness. The same can be said for mental diseases. In reality recognised mental health problems taken as a group affect at most only one quarter of the population which must be a small enough minority to make them eligible for special treatment. Boorse's assertion smacks of the kind of person who tells a woman with Obsessive Compulsive Disorder, who washes her hands until they're red raw and bleeding, "Oh, everyone's a bit OCD, you ask my husband, I can't stand crumbs on my kitchen worktops."

But this is not the end of the story. Consider the many different health issues that occur in the lungs: cancer, pulmonary embolism, pulmonary hypertension, tuberculosis. To talk of all of these as though they were one disease and illness would be a mistake. Each constitutes a different type of dysfunction to the same bodily mechanism. They are therefore different diseases and different illnesses. The same is true of mental diseases. "Neuroses' like depression, OCD, chronic anxiety, extreme phobias etc are not the same disease because they are different types of dysfunctions in the mental mechanisms for the production of beliefs and desires. If we can show that they meet the rest of Boorse's conditions they will also be different illness. Boorse saying that it is statistically normal to be significantly incapacitated by neurosis, and therefore cannot entitle you to special treatment, is misleading. Even if it were true, and the statistics seem to suggest otherwise, 'neurosis' as Boorse uses it does not refer to one disease but rather a collection of diseases. This means the number of people suffering each individual mental disease would be massively lower, even if everyone suffers from one of them. The sheer amount of ways people can deviate from natural mental functioning suggests this. Overall however, I believe the biggest problem with Boorse argument here is that his claims seem to be unfounded. The latest statistics from the *National Institute of Mental Health* on mental disorders in America tell us that the most common mental disease affecting the American population that one might categorise as 'neurosis' is

Major Depressive Disorder and this affects only 6.7 percent of adults.[127] This is a small enough group of people to entitle them to special treatment. Other 'neuroses' affect even fewer; OCD only affects only 1 percent, whilst something like Agoraphobia affects as little a 0.8 percent of Americans.[128] On top of all this Boorse's argument makes no reference to the mental disease that fall into the category 'psychosis'. Of these diseases Bipolar Disorder affects the most with just 2.6 percent of the population, Schizophrenia affects only 1.1 percent.[129] Even if we accepted Boorse's argument that 'neurosis' does not entitle you to special treatment, and I have given good reason why we should not, then mental diseases that are considered 'psychoses' still would. If it can be shown that these meet his other conditions there would be at least some mental diseases to which we could extend the label of illness.

Beyond this I think there are serious reasons to consider rejecting a disease entitling you to special treatment as being a condition for illness. If Boorse wishes to offer an account of illness that matches, at least in relation to physical illness, our folk conception of the term then the statistical approach he takes for this condition fails to do this. There are good grounds to believe that he does want to match our folk usage of the term given his attempts to validate his assessment of illness by asserting that it is in keeping with people not applying the term to plants and animals. Boorse says that not everybody can be ill and this means that if 99 percent of the population has a disease, physical or mental, then it cannot be an illness because it will not entitle them to special treatment. Imagine a situation where quite suddenly one percent of a population contracts a paralysis disease (something like Botulism) that very quickly totally incapacitates them. Boorse would quite rightly say that this is an illness, meeting all his conditions. However, if we imagine a near possible world where with similar abruptness ninety-nine percent of the population contract this disease I suggest that we would still wish to call it an illness. Boorse's 'special treatment' condition for illness means that we would have to say that it is not. If nearly everyone has it then they are not entitled to special treatment and it is not an illness. It could be though that this is not the case when we consider mental diseases. In which case Boorse may have, very indirectly, hit on something. If we accept that a certain mental disease,

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127 NIMH, *The Numbers Count*

128 NIMH, *The Numbers Count*

129 NIMH, *The Numbers Count*

for example schizophrenia, is an illness because it affects only one percent of the population, entitling those people to special treatment, would we still wish to label it as illness in a near possible world where 99 percent of the population suddenly developed it? I have a strong feeling that we would. Boorse's condition would not allow this. The reason that I think we would still consider both the paralysis disease and schizophrenia to be illnesses is because they are both *serious* and both *incapacitating* in that they severely interfere with functions for which certain mechanisms of the mind and body were naturally selected. With his three conditions for illness Boorse has attempted to reflect the serious and incapacitating nature of diseases which are also illnesses. I think that in fact his second condition fails to do this job.

iii) Excuses, Excuses

We come to Boorse's final condition, that for a disease to be an illness it needs to be a valid excuse for normally criticisable behaviour. Boorse believes that meeting this is the clearest difficulty for what we call 'mental illnesses'.[130] As I have mentioned previously Boorse holds that serious physical disease excuse us from any criticisable behaviour it may produce because we do not count the processes performed by our bodies as being among our actions. What do count as our actions are those behaviours and movements that we intentionally will. As Boorse writes "the puzzle about mental illness is that it seems to be an activity of the very seat of responsibility - the mind and character."[131] It is the mind that wills us to act in certain ways and we are responsible for our actions. For this reason Boorse argues that a mental disease cannot be used as an excuse. He does admit that this is a controversial claim and there is may be room for objectors to reject his arguments. Boorse addresses one of these possible objections. This is that, according to Boorse, mental diseases are disturbances of personality and it is not a personality that is held responsible for actions but rather persons.[132] Consciousness is a central element to the idea of a person. There are some process (of thinking, decision making etc.) that occur consciously in a person, they are aware of them, and there are others which they are not aware of that occur unconsciously. Boorse suggests that this means one might be able to

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130 Boorse, *Disease and Illness,* p. 65
131 Boorse, *Disease and Illness,* p. 66
132 Boorse, *Disease and Illness,* p. 66

claim mental diseases fall outside of a person's conscious personality.[133] It is what occurs within the conscious personality that a person is responsible for. Boorse admits that the processes that occur in relation to mental disease do seem more like things that happen to a person, much like bodily process, than like things that a person does. However, he argues this is not really the case. Our unconscious beliefs and desires still much more clearly belong to us, they are amongst *our* beliefs and desires, than the movements of our internal organs count as our movements.[134] Further, when it comes to unconscious ideas likes these it is often the case that at one time they were conscious. Similarly, through therapy it appears possible to draw out the unconscious into consciousness. If the beliefs and desires were at one point conscious or have become conscious, it becomes even harder for a person to divest themselves of responsibility for them.[135] Finally Boorse points to character disorders, where mental disease is integrated into a person's conscious personality i.e. they are ego-syntonic, as cases where it is near impossible to a person to be relinquished of their responsibility for their action and behaviours.[136]

A major part of the problem with Boorse's third condition is that he does not actually explain what normally criticisable behaviour is. I suggest that for the most part serious and incapacitating *physical* disease does not actually produce any behaviours we would normal criticise. Since Boorse does not elaborate on the matter the best I can do is to offer my own suggestions. Vomiting in public is a behaviour that I can imagine fitting the bill. It is plausible that we would only excuse this behaviour if the person performing it had a serious and incapacitating disease. It would be criticisable if the person doing it was simply ramming their fingers down their throat with the intention to shock and appall passers by. The fact is though, the vomiting reflex can be triggered by many different things and anxiety is amongst them. Were the person doing it affected by an anxiety disorder so serious and incapacitating that certain inane and innocuous situations triggered this reflex (this certainly can happen) then movements of the body involved are no more the person's action then they are when the behaviour was triggered by physical disease. I see no good reason why such a mental disease would not excuse this

133 Boorse, *Disease and Illness,* p. 66
134 Boorse, *Disease and Illness,* p. 66
135 Boorse, *Disease and Illness,* p. 66
136 Boorse, *Disease and Illness,* p. 66

behaviour. Taking time off work (outside of holidays, maternity, paternity, bereavement or some non-medical emergency) is another behaviour we might normally criticise. Similarly, so is taking time off from other duties such as looking after your family. Serious and incapacitating physical disease is a valid excuse for this. But why is it that we accept this as a valid excuse? I suggest that there is little point in somebody going to work if they are unable to do their job. It is because the disease is incapacitating that they cannot do their job and as such it provide a valid excuse for not doing it. The serious and incapacitating mental diseases that we call mental illnesses are also just that: incapacitating. If the mental disease is incapacitating enough that it means you are unable to carry out your duties in the workplace then it is a valid excuse for not doing them. When we consider that both mental disease and physical disease can provide equally valid excuses for these normally criticisable behaviours, as can many different other things, I think it becomes clear what kind of behaviour Boorse was actually thinking of when he developed this condition. Some mental disease, in particular those that result in delusions like schizophrenia and sometimes bipolar disorder, can result in people performing what most would consider heinous acts.[137] Especially when it comes to schizophrenia these acts can be extremely violent. If we accept Boorse's argument about the mind being the seat of responsibility then we cannot excuse this behaviour. We would excuse this behaviour were it the result of a serious and incapacitating physical disease. However, given the fact that no physical disease causes such behaviour or anything approaching it it seems odd that Boorse would include this condition in his analysis of illness except for the reason of ruling out mental disease as illnesses. I believe that here Boorse's is begging the question; assuming first that 'mental illness' is not a legitimate concept then adding this condition to his analysis of illness in order to rule it out.

My final note on Boorse's stance regarding responsibility relates to a debate that attracts much popular attention. In the United Kingdom where health care is open to everyone and paid for by taxation it is often questioned in the media whether certain serious and incapacitating physical diseases should treated and paid for by the NHS. It seems that we do often try an hold people responsible for the processes undertaken by their body. This is the case when

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137 The evidence suggests that such occurrences are actually quite rare (Walsh, Buchanan & Fahy 490 - 495). The Daily Mail often suggests otherwise.

people suffer serious and incapacitating disease as the result of things like smoking, alcohol abuse or overeating. Possibly we would hold someone responsible if they contracted a disease in a part of world they were advised for medical reasons not to travel to. Boorse acknowledges this, saying we may be blamed for illness when we fail to take steps to prevent the malfunction from occurring.[138] There is some sense in which we attribute to people responsibility for an illness that they have brought by choosing to act in a certain way, despite knowing what this will do to them. After that we may hold them responsible for the behaviour that illness causes them to engage in. Whilst there may be a genetic predisposition toward certain 'mental illnesses', people are not born with them. Nor, in the most part[139], do people choose to develop them. Had they a choice in the matter then they would certainly choose not to, much like people would choose not to develop physical illness. A person who develops a serious and incapacitating mental disease can be held no more, perhaps less, responsible for that development than a person who develops a serious and incapacitating physical disease. Their subsequent actions, I submit, can be blamed on that disease.

4. Conclusion

Christopher Boorse's arguments for accepting his objectivist account are perhaps not as strong as he had hoped they would be. Nevertheless I do believe it is the best way to progress in developing an account of disease. His actual account of disease faces problems because of its reliance on a statistical notion of health. For this reason I have borrowed and adapted an account from Jerome Wakefield that stays true to the spirt of Boorse's whilst avoiding these problems. As neither Boorse nor Wakefield are particularly forthcoming with an analysis of how we should understand the dysfunction involved in mental disease I have provided an account characterising it as either a dysfunction in the belief-producing or desire-producing mental mechanism.

It is Boorse's stance that an illness is a serious and incapacitating disease and that this should be reflected in three normative conditions. For a disease to be

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138 Boorse, *Disease and Illness,* p. 62

139 It could be that through substance abuse, ignoring advice to stop, a person will develop a mental disease (as seemingly happened to Peter Green and Syd Barrett) and in this case we may hold them responsible for their subsequent actions. This, however, exactly parallels cases of self-induced physical illness.

an illness it is necessary that it must be i) undesirable for its bearer, ii) an entitlement to special treatment and, iii) a valid excuse for normally criticisable behaviour. Boorse hold's that no mental disease can meet these conditions and thus cannot be given the label of 'illness'. I have argued first, that mental disease can meet these conditions just as convincingly and clearly as physical disease, and second, that each of these conditions either fails to reflect the serious and incapacitating nature of illness or is irrelevant to an analysis of the term.

Boorse argues that mental disease is not as clearly undesirable for its bearer as physical disease, because it is desires that are under scrutiny for being dysfunctional in the first place. I have show that in many cases this is not true, that it is in fact a person beliefs that are faulty, and where desire are in question the person higher-order ones remain rational. I have further argued that this condition rules out certain serious and incapacitating physical diseases. Boorse argues that mental disease cannot entitle you to special treatment because too many people are affected by it. I have shown that this is false and, further, *because* they are serious and incapacitating an illness is still an illness however many people it affects. Finally, Boorse argues that mental illness is not a valid excuse for normally criticisable behaviour. I suggest that this condition is not relevant to an analysis of disease and has only been included by Boorse to rule out possibility of certain mental disease qualifying as illness, thereby begging the question.

I therefore conclude that mental illness does exist.

Word Count: 16,218

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