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What's special about mental health and disorder?

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Glance through the *Diagnostic and Statistical Manual of Mental Disorders*,¹ published by the American Psychiatric Association, but influential worldwide, and one gets some idea of the variety of conditions that are considered “mental disorders”. One finds not only codes for types of schizophrenia and depression, but also for types of substance abuse and addiction; dementias; conditions that normally manifest in childhood, such as dyslexia, autism and bedwetting; anxiety disorders, including Post Traumatic Stress Disorder and phobias; sexual problems – which range from erectile dysfunction to pedophilia; personality disorders – deeply entrenched problems in personality - including Schizoid and Antisocial Personality Disorders; and sleep disorders, such as nightmare disorder and insomnia. What, if anything, unites this collection? Is there something special about mental health and disorder?

During the 1960s and 70s many held that mental disorders were disorders of an especially problematic type; antipsychiatrists mounted powerful challenges to the legitimacy of psychiatry as a branch of medicine.² At the extreme, mental illness was claimed to be a myth.³ These debates have now died down. The pendulum has swung the other way to the extent that those writing on the concept of mental disorder now tend to think that mental disorder is much like physical disorder. In current debates the important issue, it is assumed, is whether a condition is a disorder, or some non-pathological state (a normal variation, or a moral failing, for example). The question of what distinguishes mental and physical disorders

¹ A.P.A. 2000

² Rosenhan 1973, Szasz 1972, Laing and Esterson 1970, Foucault 1971

³ Szasz 1972

is considered to be of only secondary importance, and is dealt with, if at all, as an afterthought.⁴ Those who do examine the question of what distinguishes mental from physical disorders generally conclude that a clear-cut and meaningful distinction cannot be drawn and that the distinction should either be abandoned, or merely tolerated for book-keeping purposes (e.g. it is useful to have some agreement as to the conditions that psychiatrists will treat) .

Notably, this “ivory tower” view meets with little agreement amongst those at the sharp end of diagnosis. To many patient groups it matters a very great deal whether their label is taken to indicate a physical or mental disorder. Recently, for example, researchers who suggest that Chronic Fatigue Syndrome may have a psychological cause have received death threats from some patient activists who are convinced that the causes must be physical.⁵ The insurance industry and some law makers also continue to see a sharp division between mental and physical disorders.

This chapter examines how it is that academics and those directly affected by diagnoses can have reached such very different conclusions. How could a distinction that academics consider to be of little importance matter on the ground – and who is right? I will first consider work in the philosophy of medicine and then go on to consider the views of patient groups.

“Mental disorder” according to the academics

Academics interested in the concept of mental disorder have generally worried about the disorder part first, and the mental, if at all, only afterwards. The big problem has been taken to be how we might distinguish between the normal and the pathological. As it happens, much of the impetus for this work arose from debates about mental health issues during the 1970s, which centred on the challenges posed by the antipsychiatry movement and debate about the normality or otherwise of homosexuality. Mental health issues sparked interest in the question of what distinguishes the normal from the pathological, but the accounts of disorder that were developed are either explicitly intended to encompass both mental and

⁴ A recent article on the distinction between mental and physical disorders even starts with the claim that “it is of far greater practical importance how we draw the line between the pathological and the nonpathological than how we draw the line between mental and somatic disorders” Brülde and Radovic 2006

⁵ Feilden 2011

physical conditions, or can easily be adapted to cover both. In this section I will show how it is that current philosophy of medicine manages to consider mental and physical disorders together. I examine current accounts of disorder, and their problems, and show that the issues that arise apply equally to physical and mental disorders.

The best known account of disorder is that proposed by Christopher Boorse.⁶ Boorse holds that we can think of the human organism as being made up of various subsystems (which include solid organs, such as kidneys, and also more diffuse systems such as the nervous system). Each subsystem has a normal function, which is whatever it normally does in comparable organisms that contributes to survival and reproduction. For example, the function of my teeth is to chew food. This is what teeth do in most humans of my age and sex that contributes to survival. If my teeth fail to enable me to chew, then there is a dysfunction and I have a disorder. Boorse adopts an account of normal function that claims that the normal function of a subsystem is whatever is statistically normal for organisms of the same sex and age. However, amongst philosophers of biology there is no agreement that this is the correct account of biological normal function.⁷ Evolutionary accounts, which claim that the normal function of a biological subsystem is whatever it was selected to do, are also popular. Those tempted by the basic idea that disorders are dysfunctions, but sceptical of Boorse's account of normal function, can adopt a variant of Boorse's account by accepting his claim that disorders are dysfunctions, but adopting an evolutionary account of normal function. On such an account, my non-chewing teeth will still be said to be dysfunctional, but now past selective pressures provide the justification for saying that the function of my teeth is to chew food.

Either version of the disorder as dysfunction account might be hoped to apply also to mental disorders. With the rise of evolutionary psychology it has become commonplace to think of the mind as being made up of various mental modules each of which has one or more particular functions.⁸ One might conceive of mental disorder as occurring when one or more of these modules fails to function (with dysfunction being understood in either statistical or evolutionary terms). Indeed this pattern of explanation has become popular, most famously in

⁶ Boorse this volume, 1975, 1976, 1977, 1997

⁷ For an overview of the debates see Garvey 2007 ch7.

⁸ Tooby and Cosmides 1992

the case of autism, which Simon Baron-Cohen has hypothesised stems from a failure in the theory of mind module.⁹

However the notion that disorders can simply be equated with dysfunctions, as Boorse claims, has come in for widespread criticism. The most influential case in this regard is homosexuality. Homosexuality was considered a disorder until 1973, when the American Psychiatric Association voted to remove it from the classification of mental disorders.¹⁰ The case of homosexuality causes problems for accounts that claim that all biological dysfunctions are disorders. The problem is that, though the causes of homosexuality are debated, it might turn out to be the case that homosexuality occurs as the results of some biological dysfunction. Maybe, for example, there is some mental mechanism that normally functions so as to ensure that people are attracted to members of the opposite sex, and something goes wrong with this in cases of homosexuality. If one claims that dysfunctions are disorders, one is forced to conclude that homosexuality may be a disorder. For many participants in the debates about homosexuality, this was an unacceptable conclusion. Many claimed that whatever the biological origins of homosexuality it would not count as a disorder because it is not a bad thing. Following the debates about homosexuality, Jerome Wakefield's account of mental disorder, that claims that a disorder must not only be a dysfunction but also be harmful, became the most influential account of disorder amongst those interested in mental health.¹¹ Although homosexuality is the case that convinced most commentators, and although Jerome Wakefield proposed his account with mental disorder specifically in mind, it is worth noting that cases where a biological dysfunction does no harm, and should plausibly not be considered a disorder also occur in physical medicine.¹² Here too it is plausibly a mistake to consider mere difference that does no harm to be a disorder.

On accounts that claim that disorders are harmful dysfunctions, dysfunction is no longer sufficient for disorder but it remains necessary. Some consider even this to be a mistake. Although many mental disorders can be thought of as biological dysfunctions, there are problematic cases. Evolutionary psychopathologists have been struck by the fact that many mental disorders appear to have a genetic basis and yet occur at rates that are too high to merely be the result of random mutations. Examples include manic-depression, sociopathy,

⁹ Baron-Cohen 1995

¹⁰ Bayer 1981

¹¹ Wakefield 1992a, 1992b, 1999 adopts an evolutionary account of normal function.

¹² Amundson this volume

obsessive-compulsivity, anxiety, drug abuse, and some personality disorders.¹³ This implies that such disorders have at some stage conferred a selective advantage. For example, on some accounts the aggression and promiscuous behaviour of psychopaths may make biological sense for low-status men born into hostile environments¹⁴. If this is the case then being a psychopath is no dysfunction, and yet we would still want to consider it a disorder. For such reasons the idea that disorders can be considered biological dysfunctions has perhaps been particularly contested in psychiatry. However, similar problems can also occur in the case of physical health – consider the “thrifty phenotype” account of Type 2 Diabetes for example¹⁵. Here again it looks like some disorders arise because of a mismatch between the environment in which traits were selected and the current environment in which we live. Such cases suggest that biological dysfunction may not be necessary for disorder.

If dysfunction is abandoned as either being sufficient or necessary for disorder the field opens up for the development of a whole range of alternative accounts of disorder. One family of accounts focuses on the fact that disorders limit a human’s ability to live a good life. Chris Megone has developed an Aristotelian account which claims that a healthy human is one in which physical and mental sub-systems function in ways that enable the human to live a flourishing life.¹⁶ Somewhat similarly, both Leonard Nordenfelt’s (1995) *On the Nature of Health* and Kenneth Richman’s (2004) *Ethics and the Metaphysics of Medicine* propose that an individual is healthy if their body and mind is such that they can reasonably hope to achieve important goals (though Richman and Nordenfelt differ in exactly how this should be understood). The fundamental worry for such accounts is that they risk being over-inclusive. The problem is that there are states that limit flourishing but that we do not want to count as diseases (vices, lack of education etc) and these accounts struggle to respect this distinction.¹⁷

Another family of accounts holds on to the idea that disorders are necessarily harmful, but adds some other criteria in an attempt to more clearly demarcate disorders from other sorts of problem (educational problems, housing problems and so on).¹⁸ The extra criteria vary from author to author but may include requirements such as that disorders have to be potentially

¹³ Wilson 1993

¹⁴ Mealey 1995

¹⁵ Hales and Barker 1992

¹⁶ Megone 1998, 2000

¹⁷ Cooper 2007 develops this argument against Aristotelian accounts. Parallel arguments can be developed against the other accounts in these family.

¹⁸ Reznick 1987, Cooper 2002

medically treatable, that sufferers have to be unlucky, that diseases must be statistically infrequent, that disorders have to have some biological basis. As I see it the main difficulty with such complex accounts is that to date none has been developed in any detail, and as the devil is so often in the details, a final assessment of such accounts must wait until a fully developed account has been produced.¹⁹

For our purposes here the main point to note is that although the correct account of disorder is contested, all accounts that are currently being developed can apply equally to both mental and physical disorders. As such any distinction that can be drawn between mental and physical disorders will not simply emerge naturally out of a satisfactory account of disorder. Rather, even if a satisfactory account of disorder is developed, the problem of working out how mental and physical disorders can be distinguished will remain as a separate task.

In practice, mental disorders are frequently taken to be circumscribed by the *Diagnostic and Statistical Manual of Mental Disorders* (better known as the D.S.M.), but even the authors of the D.S.M. are not too interested in the distinction between mental and physical conditions. The current edition states

Although this volume is titled the Diagnostic and Statistical Manual of Mental Disorders, the term mental disorder unfortunately implies a distinction between “mental” disorders and “physical” disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much “physical” in “mental” disorders and much “mental” in “physical” disorders. The problem raised by the term “mental” disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute. (A.P.A. 2000, xxx)

The D.S.M.’s claim that only dualists can accept a distinction between mental and physical disorders is a philosophical blunder. Physicalists hold that all is ultimately physical, but still they may think that different varieties of ultimately physical stuff can be distinguished. Tables and chairs, and apples and pears, are all physical but can be differentiated. The mental and the non-mental physical might also be distinguishable, for example on the basis of some feature such as consciousness or intentionality.

¹⁹ I am currently working on fully developing the account proposed in Cooper 2002.

Still, though physicalists can hold that there is some distinction between physical and mental disorders, figuring out what it might be is far from easy. As the D.S.M. notes, at the level of causes and of symptoms the distinction between physical and mental disorders is far from clear-cut. “Mental” disorders frequently have multi-factorial causes that, though including psychological factors such as stress, also include physical factors such as genetic susceptibility, complications at birth and drug use. Similarly, many physical conditions are affected by psychological factors. For example, studies show that the optimistic have better outcomes in some cancers.²⁰ At the level of symptoms there is also much overlap. Mental disorders can have some physical symptoms, for example, fatigue and pain in depression, and many physical disorders can make us moody and irrational.

Classically it has been claimed that intentionality is the “mark of the mental”. Intentionality has to do with the “aboutness” of mental states - a belief is a belief about something, a desire is a desire for something, a fear is a fear of something. Derek Bolton suggests that this can be used to distinguish physical from mental disorders.²¹ He points out that intentionality is subject to normative constraints; beliefs are more or less well grounded, emotions more or less appropriate. Mental disorders, he suggests, occur where there is a radical failure to respect these constraints. Someone with delusions has ungrounded beliefs; someone with a mood disorder has inappropriate emotions. The primary difficulty with Bolton’s suggestion is that there are many conditions in the D.S.M. that it is hard to characterise in terms of dysfunctional intentionality. Consider conditions such as insomnia or erectile dysfunction, for example. If you have problems sleeping, or sustaining an erection, where’s the problem with intentionality? In later work, Bolton suggests that we might use the criteria of intentionality-failure to pick out a somewhat narrower class of conditions than those currently treated by psychiatrists.²² Call his narrower class “madness” or “insanity”. Here, though, Bolton’s interests diverge from our own, for we are considering what if anything is special about mental disorders characterised as the rather broad range of conditions that psychiatrists currently treat.

Where does this leave us? With perhaps the dominant view being that there is no clear-cut distinction that can be drawn between physical and mental disorder. Dominic Murphy considers that contingent historical pressures have led to psychiatrists dealing with a jumble

²⁰ Allison, Guichard, Fung & Gilain 2003.

²¹ Bolton 2001

²² Bolton 2008 p251-2 also notes that the conditions covered by the DSM are diverse.

of conditions. He concludes “We are left with a mess”.²³ In an influential 2001 article in the *British Journal of Psychiatry*, Robert Kendell goes so far as to claim that the view that mental disorders are “fundamentally different from other illnesses” has been “abandoned by all thinking physicians”.²⁴ He holds that differences between mental and physical disorders are “no more profound than the differences between disease of the circulatory system and those of the digestive system, or between kidney diseases and skin diseases”.²⁵

2. The mental/ physical distinction on the ground

While psychiatrists and philosophers have been relaxed about the distinction between mental and physical disorders, to many patients the distinction is a matter of grave concern. Here in seeking to get a sense of the issues, I will focus on the debates that surround two contested conditions: Tourette’s and M.E./C.F.S.. Through looking at these cases I hope to gain insight into what it means to patients to receive a mental disorder diagnosis.

Border skirmishes 1 - Tourette’s Syndrome

Tourette’s Syndrome is characterised by multiple motor and verbal tics. Stereotypically someone with Tourette’s swears uncontrollably and has an oddly jerking body. Until comparatively recently Tourette’s was considered a rare condition. Estimated prevalence was once 1-2 per thousand,²⁶ but is now 1%-2%.²⁷ As milder cases come to be diagnosed, the proportion of patients who exhibit the more extreme symptoms has decreased. Coprolalia, the involuntary shouting of swear words, was once taken as defining symptom, but is now considered rare.²⁸ Tourette’s is normally diagnosed in childhood, and often becomes most severe during adolescence.

In the United States the most vocal patient group is the Tourette Syndrome Association (T.S.A.) founded in 1972. Since their founding the T.S.A. has sought to present Tourette’s as a neurological as opposed to a psychological condition. Public information adverts issued by

²³ Murphy 2006, p.71

²⁴ Kendell 2001 p.491

²⁵ Kendell 2001, p.491

²⁶ Roberston 1989 p148

²⁷ Swerdlow 2005

²⁸ Swerdlow 2005 p 330.

the Association have consistently taken this line. One in the mid-seventies informed readers that “Most victims accept it as an emotional problem, which it is not, Many doctors, too, misdiagnose it as mental disorder. But it is physical!”²⁹ The T.S.A. formed alliances with researchers who postulated organic etiologies for the disorder. In his histories of Tourette syndrome, Howard Kushner argues that the activities of the Tourette Syndrome Association have been highly effective.³⁰ He suggests that the reason that researchers in the U.S. now believe that the disorder has an organic basis, while in other countries, such as France, psychodynamic explanations still predominate, can be traced to the activities of the Association.

Those who argue that Tourette’s has an organic basis commonly point out that family studies suggest a genetic component to the disorder.³¹ Some theorists suggest that the condition may be caused by some problem with the basal ganglia, a brain region that is thought to play a role in inhibiting unwanted behaviours.³² However, other features of the disorder are more suggestive of a psychological element. Tourette’s is frequently co-morbid with Attention Deficit Hyperactivity Disorder or Obsessive Compulsive Disorder, making links with these conditions a possibility.³³ As with so many conditions, the severity of symptoms can vary over time, often becoming worse with stress. Sufferers can often control their tics to the extent that they can hold tics back for some period of time, maybe twenty minutes, before discharging them at a later point (some describe the urge to tic as being similar to the urge to sneeze). Many patients report that releasing a tic feels voluntary.³⁴ While most motor tics are apparently meaningless, some verbal tics bear at least some of the hall-marks of intentionality, for example, “fat pig” may be shouted only in the presence of the obese, or “nigger” only in the presence of black people.

Claiming that Tourette’s is neurological has become important to patients both at a personal level and in lobbying for various changes to public policy. At the personal level it is common to find patients and their parents speak of their “relief” at hearing that Tourette’s is a physical disorder.³⁵ In part, to claim that Tourette’s is a physical disorder is to make a claim about what it is not. For some, a physical disorder is specifically not the sort of condition that can

²⁹ Kushner 1999 p.181

³⁰ Kushner 1999, 2004

³¹ Swerdlow 2005

³² Mink 2001

³³ Robertson 1989, Swerdlow 2005.

³⁴ Leckman, Walker, Cohen 1993.

³⁵ Kushner 1999 p.176.

be explained by psychoanalytic theory, or by other psychological models that trace disordered behaviour to faulty upbringing. Many parents and patients can recall unhappy experiences with psychoanalysts in the seventies and eighties. One mother recalls “the really tragic part of it was that the psychiatrists we went to would all blame me for Bill’s problems. Right in front of me, they would ask him, “What has you mother been doing to you”.³⁶ More recently the jacket of a biography written by another parent proclaims that the neurological diagnosis means that “His behaviour is NOT OUR FAULT!”.³⁷ To claim that Tourette’s is physical rather than mental is to claim that no-one – neither the child-patient, nor their parents can be blamed for it.

At the level of public policy, claiming that Tourette’s is a neurological condition has become important in a number of debates. Newman analyses the rhetoric employed by the T.S.A. in a recent campaign to ensure that children with Tourette’s receive particular accommodations in schools.³⁸ In the U.S., the legislation that ensures that disabled children receive special education makes the type of educational adjustment dependent on the type of disability. There are only a limited number of categories of disability, meaning that children with Tourette’s must be placed in one pigeon-hole or another. In many cases children with Tourette’s had been classified as Emotionally Disturbed, a decision that led to children with Tourette’s being placed in special classrooms for emotionally disturbed children, and in some cases being subjected to programs that aim to adjust behaviour via systems of rewards and punishments . The T.S.A. campaigned to have children with Tourette’s instead classified as Other Health-Impaired, a classification that encompasses children with epilepsy, A.D.H.D., asthma, and rheumatic fever. The legislation was due to be revised in 2003, and the T.S.A. lobbied for Congress to facilitate the reclassification of children with Tourette’s. The letters directed to decision-makers emphasised that Tourette’s is a “neurobiological disorder”. This lobbying eventually succeeded and Tourette Syndrome is now explicitly mentioned as an example of Other Health Impaired.

What should we make of these debates? The debates about Tourette’s show clearly how the distinction between mental and physical disorders can make a difference to patients. First, a mental disorder diagnosis opens up the possibility of blame. While those who suffer from physical conditions may be conceived of as being blameless victims, the moral status of those

³⁶ Kushner 1999 p. 176

³⁷ Hughes 1990, capitals in original.

³⁸ Newman 2009

diagnosed with mental disorders and their families may be more ambiguous. Second, whether Tourette's is considered mental or physical matters because such categories play a role in organising bureaucracies – those with physical disorders are processed differently than those with mental disorders. In this case school children will be treated differently depending on whether their diagnosis is conceived of as a physical or mental disorder.

Border skirmishes II: Myalgic Encephalomyelitis (M.E.)/ Chronic Fatigue Syndrome (C.F.S.)/ Chronic Fatigue Immune Dysfunction (C.F.I.D.).

Everything about M.E./ C.F.S./ C.F.I.D. is controversial. Starting with the name: Patient groups frequently prefer terms which are suggestive of a biological cause - Myalgic Encephalomyelitis (in the U.K.) or Chronic Fatigue Immune Dysfunction (in the U.S.). In contrast Chronic Fatigue Syndrome, a term frequently used by medics, has no overtones of organicity. Here I will follow the terminology that has become commonplace in much of the literature and refer to the condition as C.F.S./M.E. The disorder is characterised by fatigue, associated with somatic complaints such as joint pains and headaches, which last at least six months. In part the diagnosis is made on the basis of exclusion – by definition no organic cause for the syndrome must be found. The condition can be extremely disabling. Many sufferers are forced to give up work and may be bed-bound.

The causes of the condition are unknown. Some believe that some sort of virological or immunological cause will be likely. Others think the condition is psychosomatic. Mixed views hold that the condition may have an organic origin and then be made worse by psychological factors. Controversy rages over the use of treatments which include Cognitive Behavioural Therapy and Graded Exercise programs. Some patient groups take such psychological and behavioural treatments to be suggestive of the idea that the condition is psychological. The studies proving such treatments effective are contested.³⁹ One area of debate concerns the diagnostic criteria that should be used to select subject groups for study. These debates are entangled with debates about the supposed origins of the disorder, and so

³⁹ Jason, Richman, Friedberg et al 1997.

resolving them is far from straightforward. Those who think that C.F.S./ M.E. is allied to other psychosomatic conditions favour broad definitions of the condition. They think that patients with C.F.S./M.E. are basically the same as those with other medically unexplained somatic complaints.⁴⁰ Using such criteria some studies have found that interventions such as graded exercise have been useful. However, those who think the condition likely organic favour a tighter definition.⁴¹ They think that a core group of C.F.S./M.E. sufferers have a condition with an organic cause, and that these patients need to be distinguished from look-a-likes who suffer from psychologically-caused syndromes. Researchers who adopt narrower criteria find interventions such as graded exercise programs to be of less use.⁴²

The debates between those favouring a biological cause and those who suspect a psychological cause have become unusually heated and personal. I suggest two major reasons why the debates about C.F.S./M.E. are so very problematic. First, C.F.S./M.E. can be an extremely debilitating and chronic condition. This means that there are major economic issues tied up with how it is classified and perceived. Insurance companies have an interest in the condition being dismissed as somehow unworthy of consideration. On some insurance programs it makes a difference whether a condition is considered a mental or physical condition. Recent parity laws introduced in the U.S., which require certain forms of insurance to cover mental and physical disorders equally, mean that this is less of a problem than it used to be, but the scope of the legislation is limited, and in many cases insurance continues to pay out less for mental than for physical conditions.⁴³ Here making the disorder appear mental has major economic implications.

Secondly, and tied up with the economic issue, patients with C.F.S./M.E. are frequently suspected of malingering – that is claiming to have symptoms that they do not for financial gain. Estimates of levels of malingering amongst benefits applicants who claim to have C.F.S./M.E. are up to 35%.⁴⁴ Such statistics need to be treated critically. On the one hand, it is certainly the case that some patients claiming to have C.F.S./M.E. are malingerers. Some applicants are caught out by video surveillance; they may claim to be unable to walk but are videoed jogging.⁴⁵ On the other hand, many of the large numbers of patients who are

⁴⁰ Wessely, Nimnuan, Sharpe 1999

⁴¹ Jason 2011

⁴² Jason, Richman, Friedberg et al 1997

⁴³ Hitt, 2010

⁴⁴ Mittenberg, Patton, Canyock et al 2002

⁴⁵ DeLuca 2008

suspected of malingering are suspected solely because their physician thinks their symptoms fishy – whether this suggests that the patient is a malingerer or that the physician is unsympathetic to those with C.F.S./M.E. is anyone’s guess. Furthermore the hurdles around claiming benefits are such that legitimately sick patients may find they can only be gained via “acting sick”. Obtaining benefits can be a hit and miss affair. It thus helps if one self-presents in a particular way – it is better to look scruffy than well-presented for hearings, better not to fill in forms in an overly neat way, better to rate symptoms on bad days. Advice on such matters is shared on online support groups.⁴⁶ A sick patient may have to act sick to maximise their chances of receiving the benefits that are legitimately theirs, but still onlookers might find something about their behaviour suspicious. In response to concerns about malingering, some insurance providers in the U.S. have introduced a category of disorders known as “self-reported” or “subjective” which covers disorders that are diagnosed on the basis of self-reported symptoms.⁴⁷ The insurance pays out at a lower rate for these conditions. Such a category enables these insurers to sidestep the question of whether C.F.S./M.E. is physical or mental.

The fundamental problem for patients with C.F.S./ M.E. is that there is no biomarker for the condition. The non-objectivity of their symptoms means that C.F.S./M.E. sufferers are treated with suspicion not only by insurance companies, but also by some medics and lay people. Patients thus face a constant battle to prove the legitimacy of their claims to illness. In this context, for C.F.S./M.E. patients a good doctor is not necessarily one who offers treatment, but is one who “believes in ME” and fills in forms for benefits.⁴⁸ “Believing in M.E.” tends to be equated with holding that the disorder may well turn out to have an organic basis. In this conflation of the question of whether C.F.S./ M.E. has a physical origin and the question of whether it is a “real” disorder we see an example of what Nicholas Rose has characterised as a recent “flattening” of psychological space.⁴⁹ His suggestion is that while in the first half of the twentieth century lay conceptions of the mind came to embrace notions of the unconscious, and thus psychological space came to have depth, by the end of the twentieth century notions of the psychological had flattened. Now the perceived options for the causes of behaviour are limited – either behaviour is intended or it has an organic cause. In such a context it is understandable that patients with C.F.S./M.E. are often highly resistant to any

⁴⁶ Davis 2002, Dumit 2006.

⁴⁷ Dumit 2006

⁴⁸ Guise, McVittie, McKinlay 2010.

⁴⁹ Rose 2007

suggestion that it might be a psychological condition. They tend to present their disorder as somatic – often tracing onset to some post-viral state, fatigue and aches and pains described as of organic origin.⁵⁰ As medics often hold that the disorder is psychogenic, this can lead to tension in consultations.

At the political level too, C.F.S./M.E. patient groups are keen to present the condition as having an organic basis. The condition is not currently included in the D.S.M., and is in the W.H.O. classification under Disorders of the Nervous System. However, the condition's status as a neurological disorder is fragile. In one study 84% of British neurologists said that they did not consider C.F.S./M.E. to be a neurological condition.⁵¹ Patient groups are alert in monitoring any changes to classification systems that mean that C.F.S./M.E. might come to be classified as mental. In recent consultations about plans for the forthcoming D.S.M.-5, various patient groups wrote to the American Psychiatric Association to express concern over a proposed category, Complex Somatic Symptom Disorder, which they feared could be used to give C.F.S./M.E. sufferers a psychiatric label.⁵²

What can we draw from this debate? The essential problem for patients with CFS is the non-objectivity of the symptoms and the lack of a biomarker. This leads to claims for benefits being denied or only grudgingly granted, and to patients being treated with suspicion. Even when the patient is agreed to have a “real disorder” the benefits that are paid to those who suffer from “mental disorders” or “subjective disorders” are often lower than those paid to those who suffer from physical disorders. There are various historical reasons why insurance in the U.S. has traditionally given only reduced benefits for “mental disorders”,⁵³ however one obvious reading of why it is that such limitations have been tolerated for so long is that both “mental disorders” and “disorders characterised by subjective symptoms” are considered to be only dubiously disorders. In this respect “mental disorders” and “subjective disorders” are only half-way medicalised – and patients are granted the sick-role only grudgingly and to a limited extent. Given that society treats mental disorders as only being dubiously disorders, it is understandable that patients with C.F.S./ M.E. hear suggestions that the condition may be psychological as being dangerously close to claiming that it is unreal.

⁵⁰ Banks, Prior 2001

⁵¹ Wojcik, Armstrong, Kanaan 2011.

⁵² McCleary 2010

⁵³ Cooper 2005 pp.127-129

Conclusions - What's special about mental health and disorder?

While academics have tended to think of the distinction between mental and physical disorders as being of little importance, patient groups disagree. In this chapter I set out to determine who is right. Now we can see that both sides have some justification for their claims. The academics are right in saying that there is no one common feature that all and only mental disorders share. On the other hand patient groups are right to care whether their condition is counted as a mental disorder. While a tradition amongst academics has it that there is no genuine distinction between mental and physical disorders, and that thus any differences in treatment are down purely to prejudice, I will suggest this view is incorrect. I suggest that mental disorders are treated differently from physical disorders in part because amongst them are many that are particularly troubling. Many amongst the mental disorders are only dubiously disorders and for this reason it comes to be stigmatising for one's condition to be labelled a mental disorder.

Disorders can be only dubiously disorders for two main reasons. First there are conditions that shade into normality – here we find it hard to know whether a condition is normal or not. Of course there are physical disorders that shade into normality, such as high blood pressure, and obesity. However in physical medicine the boundaries of such conditions tend to be policed by the introduction of an arbitrary and yet objectively measurable cut-off point; only those with blood pressure reading of X, or a B.M.I. index of Y will be said to suffer from a medical condition and will receive treatment.

On the other hand, many mental disorders are problematic in that they both shade into normality, and also do not have an objectively measurable cut-off point. While there are scales that will provide scores for depression or anxiety, these are all too clearly based on what a patient reports, and so lack the authority of a quantifiable bodily measure. The problem of shading into normality affects most mental disorders: depression, personality disorders, anxiety, substance abuse, insomnia, A.D.H.D. – in their milder forms all clearly merge into the normal.

Disorders also become dubious when they shade into moral failings. Problems with this dimension are far more common with mental disorders than physical disorders. While some think that smoking lung cancer sufferers bring it on themselves, here we have only moralising regarding the cause of the disorder. In contrast in some mental disorders it is genuinely unclear whether the condition itself is a disorder or a vice. This ambiguity is clearest with the

personality disorders. Personality disorders are life-long conditions that are highly resistant to treatment. Many are characterised in distinctly moral terms. Those with Antisocial Personality Disorder “frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights and sufferings of others”⁵⁴. Symptoms of Narcissistic Personality Disorder include “a grandiose sense of self-importance” and taking advantage of others.⁵⁵ Certain disorders of childhood are also uncomfortably close to moral problems. Children can be diagnosed with Conduct Disorder if they persistently engage in behaviours that are aggressive, destructive of property, deceitful and violate accepted norms and rules. Oppositional Defiant Disorder is a diagnosis for children who oppose authority. Problems also emerge with alcoholism and the drug addictions. While some addicts would very much like to be rid of their addictions, others drink or take drugs because these activities have become central to a lifestyle that they value.⁵⁶

To add to those conditions that are clearly on the borderline between vices and disorders, the psychoanalytic tradition comes very close to blaming patients, or their parents, for conditions that superficially appear blameless. For example, traditional accounts of psychosomatic disorders have it that secondary gains (for example, being looked after by relatives) provide the motivation for the patient to be ill. While analysts may seek to avoid blaming their patients despite holding such theories,⁵⁷ it is hard for lay people to follow suit.

Many mental disorders are problematic in that it is unclear whether they are disorders or moral failings. In contrast, the only physical disorder I can think of where the condition itself rather than merely the cause is subject to such moralising might be obesity.⁵⁸

A powerful line of academic thought claims that although mental illness tends to be more stigmatised than physical illness this is merely because of prejudice, and can be remedied by educational efforts.⁵⁹ I suggest that this is not the case. Consider the specific types of mentally ill people that lay people would prefer to avoid: top of the list are Antisocial Personality, Pedophilia, Factitious Disorder, Exhibitionism, Voyeurism, Cocaine

⁵⁴ APA 2000 p703

⁵⁵ APA 2000 p717

⁵⁶ Fingarette 1988

⁵⁷ See Pickard 2011 for an interesting account of how it is possible for therapists to hold patients responsible but not blame them.

⁵⁸ Townend 2009

⁵⁹ Kendell 2001; Byrne 2000; Rüsçh, Angermeyer, Corrigan 2005

Dependence.⁶⁰ Such disorders are genuinely perplexing, in that it is unclear whether they should be considered disorders or moral failings or both. In addition, persons with these conditions genuinely do exhibit behaviours that make it prudent to avoid them.

I hold that some mental disorders are intrinsically morally problematic. However, following a suggestion by Charlotte Blease,⁶¹ I also think that we have a tendency to impute moral failing to those who suffer from some mental illnesses unfairly. Blease considers lay responses to depression. Blease suggests that we find the existence of depression threatening to the optimistic worldview that we prefer to adopt. We want to believe that life is generally good and meaningful, and that we will get what we deserve. Depressed people threaten this belief. In an effort to avoid drawing the obvious conclusion – that life can be horrible for some people through no fault of their own – we tend to clutch at other hypotheses – that depressed people are whinging and their life isn't really so bad, or that they are somehow to blame for their condition. Such thinking is plausibly part of a broader pattern of commonplace psychological defences which come into play when our belief in a just and benevolent world is threatened. In a series of experiments Melvin Lerner found that when we are faced with suffering that we cannot alleviate we have a tendency to unfairly blame the victim for their predicament or underestimate the extent of their suffering.⁶² Following Blease, I suggest that the awfulness of severe mental illness, and our relative powerlessness in the face of it, can thus lead us to unfairly suspect that such conditions are only dubiously disorders – that sufferers are morally responsible or exaggerating their suffering.

To conclude in this chapter I set out to examine what, if anything, is special about mental health and disorder. While academics who have examined the issue frequently suggest that the distinction is meaningless and should be abandoned, many patient groups are deeply concerned to avoid a mental health label for “their” condition. I have argued that both the academics and the patient groups are correct. There is no clear-cut way of distinguishing mental from physical disorders. Those disorders that are considered mental have come to be so considered for a mish-mash of frequently contingent historical reasons. This being said the desire of many patient groups to avoid being diagnosed as suffering from a mental disorder is completely understandable. Amongst those disorders that are considered mental are a disproportionate number that are only dubiously disorders, either because they shade into

⁶⁰ Feldman and Crandall 2007

⁶¹ Blease forthcoming

⁶² Lerner 1980

normality or because it is unclear whether they should be considered disorders or moral failings. As some mental disorders are only dubiously disorders, mental disorders as a class have come to be stigmatised and only partially medicalised.

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