The Medicalization of Love and Narrow and Broad Conceptions of Human Well-Being

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Abstract: Would a "medicalization" of love be a "good" or "bad" form of medicalization? In discussing this question, Earp, Sandberg, and Savulescu primarily focus on the potential positive and negative consequences of turning love into a medical issue. But it can also be asked whether there is something intrinsically regrettable about medicalizing love. It is argued here that the medicalization of love can be seen as an "evaluative category mistake": it treats a core human value (love) as if it were mainly a means to other ends (viz. physical health and hedonic well-being). It is also argued that Earp et al's closing argument (that a scientific perspective on love actually adds more value to love) can be seen as involving another evaluative category mistake: it treats an object of desire and practical interest (namely, love) as if it mainly were an object of scientific contemplation and theoretical interest. It is concluded that, to relate love to health and well-being in a more satisfying way, we should construe the latter two in broader ways, whereby love is itself a component or element of human flourishing.

Keywords: love; medicalization; human enhancement; category mistakes; well-being

In *Make Love like a Prairie Vole*, marriage therapist Andrew G. Marshall offers tips about how couples can approach their lovemaking in order to make their relationships more like those of prairie voles: long-lasting and monogamous.[1] Some scientists have taken a more radical approach to their study of vole monogamy. One research team transferred genetic materials (vasopressin receptors) from the prairie vole into the brains of their polygamous cousins, the meadow voles. The result: the meadow voles abandoned their polygamous ways and started behaving monogamously, just like the prairie voles. A different study tried another approach: either increasing or reducing the level of the hormone and neurotransmitter oxytocin in the prairie voles. With decreased oxytocin levels, monogamous behaviors declined. With increased levels, they intensified.[2]

Because gene therapy and hormonal treatments can be used to alter the "romantic" behavioral patterns of nonhuman animals in such ways, there is reason to suppose that it can also be done in the case of humans and their romantic relationships. Indeed, drugs like antidepressives (SSRIs) have already been found to affect people's emotional responses to those around them in noticeable ways (sometimes by having a numbing effect and sometimes by increasing certain attitudes, such as willingness to cooperate).[3] This all raises the following question. Should we try to directly develop "love drugs" that could be used to bring our romantic relationships and the behaviors and

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feelings associated with them under greater control?

In a series of articles on potential "biomedical enhancements" of love and human attachment, the bioethicist Julian Savulescu and his various coauthors (including Anders Sandberg and Brian Earp) have argued in favor of a resounding yes to this question. As Savulescu and Sandberg put things in an agenda-setting 2008 article: "Love is one of the fundamental aspects of human existence. It is to a large part biologically determined. We should use our growing knowledge of the neuroscience of love to enhance the quality of love by biological manipulation."[4] Should we? Is this really a good idea? What kind of objections and worries might be raised in regard to using "biological manipulation" to alter and control the different feelings and motivations involved in human love?

One worry is that this would amount to an objectionable form of "medicalization" of love. As sociologist John Evans expresses this concern: "[Many] have reached the normative conclusion that they do not want to live in a world where increasing swaths of human experience are under the logic of medicine. . . . We can all fear the medicalization of love."[5]

This objection to biomedical enhancement treatments of love relationships is the topic of this article. In particular, the article does two things: It considers and critically evaluates Brian Earp, Ander Sandberg, and Julian Savulescu's discussion of this medicalization objection.[6] And it develops an alternative interpretation of just what the medicalization worry amounts to, which is not discussed by Earp and his coauthors. As Erik Parens argues, there can be "good" and "bad" forms of medicalization, if "medicalization" is defined as the process whereby something previously nonmedical is transformed into a medical issue.[7] The question is whether the medicalization of love is an undesirable or regrettable form of medicalization, and whether Earp et al. have considered and properly evaluated the most crucial ways in which the medicalization of love could be seen as a bad form of medicalization. I argue that the medicalization of love can be seen as a form of "evaluative category mistake." I also argue that the wish to turn love into a medical issue is likely to rest on an overly narrow conception of human health and well-being.

Love as a Means to Health and the Possible Bad Effects of Medicalizing Love

In their work on love and biomedical enhancements, Savulescu and his coauthors follow biological anthropologist Helen Fisher in dividing human love into three different stages: lust, attraction, and attachment.[8] General feelings of sexual lust inspire people to seek partners. Attraction makes people home in on particular prospective partners. And when all goes well, the crucial third stage of attachment helps to cement a bond between the lovers. Each stage of love is associated with particular hormonal changes and reactions. The operation of the lust system is "largely associated with the hormones estrogen and testosterone in both men and women." Attraction is "associated primarily with adrenaline, dopamine, and serotonin." And the attachment system is "associated mainly with the neuropeptides oxytocin and vasopressin."[9] By firmly bringing these hormones and the ways in which they operate under our control with the help of gene therapies and enhancement drugs, we could become able to bring the different stages of love—including the all-important third stage of attachment and pair bonding—under our

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control, too. Or so Savulescu and coauthors argue.

In their joint article in this journal, Brian Earp, Anders Sandberg, and Julian Savulescu advance a strictly medical argument in favor of using these envisioned kinds of biomedical enhancements of love:

> There exists a substantial amount of evidence that human love and relationships are *already* deeply implicated in such uncontroversially 'medical' phenomena as physical health and longevity. Positive interpersonal relationships yield a wide array of medical benefits including improved coping with major illnesses; indeed, the "influence of social relationships on the risk of death [is] comparable with [or even exceeds] well-established risk factors for mortality" such as smoking, drinking, lack of exercise, and obesity. By contrast, relationship dysfunction and loneliness are damaging to health and well-being and can lead to such outcomes as illness, depression, and inflamed immune responses of the type that contribute to arthritis and coronary heart disease. Hence, as we argued in a recent paper: ". . . treatment modalities aimed at addressing relationship health . . . seem to be well worth investigating."[10]

In the above-mentioned 2008 article, Savulescu and Sandberg make a similar argument. They particularly emphasize the positive effects of love on well-being, which they seemingly primarily understand in hedonistic terms:

> From a purely hedonic perspective love is . . . desirable. Close relationships promote many forms of human well-being and being married has a strong positive effect on happiness, a happy pair bond being one of the most important determinants of happiness. Love is healthy. . . . Conversely . . . happiness ratings suffer and depression risk increases among the separated and divorced.[11]

Hence, in their positive case for using biomedical enhancements to promote and enhance love, Savulescu, Earp, and coauthors strongly emphasize the positive effects of love relationships on health and well-being. Health, in these articles, is primarily understood in terms of longevity, and an absence of and immunity to diseases. Well-being is not explicitly defined in a hedonistic way. But the hedonic aspects of human well-being (joy and life satisfaction) are the main elements of well-being that are emphasized and discussed. Love and love relationships are primarily treated as means to these other ends, not as intrinsic goods or ends in themselves.

When Earp et al. discuss the worry that this approach might be an objectionable form of medicalization of love, they also mostly focus on potential effects and consequences. They do end their article with an interesting short discussion of whether there is something inherently objectionable about their overall view of love, and we will return to that discussion subsequently. However, the main focus of Earp, Sandberg, and Savulescu's article is on the possible good and bad effects of the medicalization of love.

It is important to note that Earp and company do not try to diminish the possible bad effects of turning love into a medical issue. The medicalization of love, they write, might potentially (1) be part of a "pathologization of everything," (2) result in an "expansion of medical social control," (3) create a "narrow focus on individuals rather than the social context," (4) suggest a "narrow focus on the biological (or neurochemical) rather than the psychological," and (5) constitute a "threat

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to authenticity" and an "undermining of the true self."[12]

These are all possible negative consequences of medicalizing love that Earp and coauthors think we need to take seriously. But, as they see things, these potential bad effects of medicalizing love can be checked and balanced by various positive counterforces. And, on the whole—Earp et al. further argue—it is likely that the positive consequences of turning love into a medical issue are going to outweigh the negative effects.[13] Therefore, they conclude, we should not fear but welcome the prospect of using biological manipulation to enhance love: in so doing, we can promote health and well-being.

Are questions about potential effects and consequences—whether these would primarily be negative or positive in nature—the chief questions we should concern ourselves with in evaluating whether the medicalization of love would be a bad or good form of medicalization? Or might there also be ways of understanding the medicalization worry that don't principally have to do with consequences but rather have to do with the very idea of a medicalization of love? Might there not be something intrinsically regrettable about treating love as a medical issue: as an instrument or means to other goods, such as physical health and hedonic well-being? Let us now consider these questions.

Evaluative Category Mistakes

In his "On Good and Bad Forms of Medicalization," Erik Parens also devotes much of his discussion to the potential good and bad effects of medicalizing different areas of human life, much like Earp and coauthors do when they discuss the medicalization of love. But Parens also discusses the idea that medicalization can in certain cases be regarded as a basic "category mistake."[14] In general, a category mistake is a mistake whereby something in some distinctive category is treated—or written or argued about—as if it belonged in some other category to which the thing in question does not properly belong. The medicalization of some human concern is a category mistake when it mistakenly treats this concern as if it were a medical issue, even though it really is inappropriate or infelicitous to regard it as such. The idea here is not just that certain bad consequences might unfold as a result of our treating the thing in question as a medical matter. It is, rather, that there is something inherently confused or mistaken about treating it (whatever it might be) as a medical issue in the first place.

Consider now what we might call an *evaluative* category mistake. An argument, practice, theory, or other treatment of some issue commits an evaluative category mistake when it treats a certain kind of value as if it were a value of a wholly different sort—that is, when it involves some categorical mistake or confusion about how to properly value something, or about how this thing is usually valued by most reasonable people.

Although he does not use the term "evaluative category mistake," this seems to be what the philosopher T. M. Scanlon has in mind when he writes the following in his influential book *What We Owe to Each Other*: "Understanding the value of something is not just a matter of knowing how valuable it is, but rather a matter of knowing how to value it—knowing what kinds of actions and attitudes are called for."[15] As a key example of how to value something—and also of how not to value something—Scanlon discusses the value of human life. It would be a mistake, Scanlon argues, to think of human life as something to be "maximized." That is, we don't value human

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life in the right way if we try to maximize the number of human beings that are alive, as we might do if we all tried to have as many children as possible, no matter what consequences this might have for those children. A more proper way to value human life, Scanlon writes, is to respect and cherish it once it has come into existence, and to not destroy human life in an arbitrary or whimsical way. Human life, on this picture, has great value. But it would be an evaluative category mistake to propose that it should be maximized.[16]

Another kind of evaluative category mistake concerns the distinction between means and ends, or instrumental and intrinsic values. It consists in valuing something as an end in itself, where this thing is really better regarded as a means to some other valuable end. Or, alternatively, it can also consist in treating something as a mere means, where this thing is commonly and more sensibly regarded as one of the core ends or intrinsic human goods.

An example of confusing means for ends is featured in John Stuart Mill's discussion of money in his *Utilitarianism*.[17] Those who value and seek money as an end in itself mistake a means for an end, Mill claims. An example of mistaking ends for means—or, at least, of one school of philosophy accusing another of confusing ends for means—is the classic Stoic criticism of the Epicureans' view of the role of virtue in human life. According to the latter, virtue is an efficient means to inner tranquility and pleasant social relations. The Stoics famously protested that this was a mistake, because—as they saw things—virtue is a worthy goal and end in itself, not just a means to some other end.[18]

Whether we agree with these particular examples is not important here. What matters for our purposes is instead the overall plausibility of the general idea that practices, philosophies, intellectual trends, or theories can sometimes reasonably be seen as confusing means for ends, or ends for means.

The Medicalization of Love as an Evaluative Category Mistake

Let us now return to Evans's claim that "we can all fear the medicalization of love." What, if anything, is he putting his finger on? We might find it a little overly dramatic to speak of having to "fear" the medicalization of love. But it does appear reasonable to think that there is something in itself regrettable about the prospect of medicalizing love. The question is how best to articulate this sentiment. We have seen that Earp and coauthors interpret it as a set of concerns about the potentially bad consequences of turning love into a medical issue. It is plausible to think, however, that the underlying worry about the medicalization of love is better articulated as being a nagging feeling that the medicalization of love encompasses an evaluative category mistake.

Consider first the last kind of evaluative category mistake discussed previously, whereby something that is generally and reasonably regarded as a basic end or core human good is instead mistakenly treated as a mere means to some other end. It is tempting to think of the medicalization of love as resting on this type of evaluative category mistake. In the arguments from Earp et al. and Savulescu and Sandberg quoted previously, love is chiefly treated as a means to (1) physical health and (2) hedonic well-being. It is argued that we should use hormonal drugs and gene therapies to bring about and sustain love attachments because this is a good way to avoid diseases and promote longevity. And it is argued that we should use love enhancers because love is a source of hedonic satisfaction,

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and because a lack of love is a leading cause of depression. This all suggests that love is not mainly an end in itself within human life but rather a means to other ends, such as health and hedonic well-being. That does not fit with how love is usually valued.

To find love—to love and be loved—is commonly regarded as one of the most desirable and important core values of human life. It is one of the few things almost universally regarded as an end in itself, or a good on its own account. Love is depicted, celebrated, and serenaded in all major human art forms: in paintings, novels, plays, films, poems, songs, and so on. It is the most common subject matter of some of these art forms. It is an endless topic of discussion, debate, philosophical argument, and gossip. As it is ordinarily treated, sought after, and thought about, love is anything but a mere means to certain other ends, however worthy and desirable those other ends might also be on their own account.

For these reasons it is tempting to view the medicalization of love as a sort of evaluative category mistake. It demotes, or reduces, love (an intrinsic good) to a mere means to something else—namely, health and purely hedonic well-being. It treats love as if it were a mere instrument in the prevention of disease and depression, and in the promotion of longevity and pleasant feelings. These are in themselves very worthy ends. But to propose that we turn love into a medical issue, and that we then use love drugs to initiate and sustain love relationships, nevertheless seems to embody a mistaken view of what sort of value people usually place on love. They don't think of it, and treat it, as an instrument or means to other ends. People instead give love an elevated status within their lives and treat it as a supreme good and end in itself. The medicalization of love, it seems, would fail to fully recognize and properly respect the distinctive value that most people put on love as a goal and end on its own account.

At this point Earp et al. might reply that this objection overlooks the concluding discussion at the end of their article. As mentioned previously, Earp and coauthors end their article with a fascinating brief discussion about whether their approach rests on a mistaken way of conceiving of love. They write:

> There may be a deeper worry . . . and that is that the medicalization of love, or even just the study of love from a scientific perspective, will somehow rob it of its value and importance—reducing it to a set of mindless chemicals. . . .
>
> Part of the magic of love, it seems, is that it can be so mysterious and wonderful. . . . Do we really want to put it under a microscope? All for the sake of 'health' or . . . 'well-being'?[19]

To this question of whether a medical and scientific perspective on love diminishes its value and importance, Earp and coauthors firmly respond in the negative. A deeper scientific understanding of love, its underlying biochemistry, and its health-promoting role in human life can be fascinating in its own right. It can even be enchanting. It can, Earp et al. write, potentially "open up [new] poetic vistas." It can render love "even *more* beautiful" to us.[20] Rather than undermining the value of love, a medicalization of love could add a wholly new dimension of value to it. Or so Earp et al. argue.

There is something inspiring and almost contagious about Earp, Savulescu, and Sandberg's enthusiasm and their scientific interest in love. It is not hard to understand the fascination that love and love relations can awaken in the

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observer who approaches them with a scientific eye and a microscope. But, at the same time, this approach can nevertheless be seen as involving another sort of evaluative category mistake. It can be seen as involving an evaluative category mistake of the first sort introduced previously. It clashes with the mode or manner in which people normally value love when they treat it as one of the most important human goods.

When Earp et al. talk about the distinctive kind of value that a medicalization of love could help to bring our attention to, they treat love as an object of intellectual contemplation, or of scientific interest and study. This is certainly one way in which we can think about and value love. But it is very different than the way in which love is usually regarded and valued; it is not the general mode of valuing that's typically employed by those who treat love as one of the core human goods. Love is usually valued as an object of desire. It typically functions as a practical interest: as something we actively pursue for its own sake. It is usually not valued as an object of study, or a purely theoretical interest.

That the medicalization of love could enhance its value as an intriguing object of study and theoretical interest does not help to answer the worry that a medicalization of love might diminish or misunderstand its distinctive value as an object of desire and practical interest. The connotations and associations under which people desire and seek love are different, and mostly independent, from the features of human love that make it theoretically fascinating as an object of scientific study.[21] This is why the discussion toward the end of Earp and his coauthors' article can be thought to involve another evaluative category mistake. At least that is so if that part of their article is supposed to ease the worries people might have about the medicalization of love. It does not speak directly to those worries, because they derive from our practical interest in love, and that last part of their paper talks about love under the guise of it as a fascinating theoretical interest.

To summarize the overall argument of this section: an important underlying reason for which we might find the medicalization of love regrettable is that it seems to involve an evaluative category mistake. It seemingly involves a mistake about how to properly value love. It appears to reduce or demote love to the status of a mere means or instrument to certain other ends (physical health and hedonic well-being), whereas love is usually regarded as a core human good on its own account, or an end in and of itself. And although Earp and his coauthors' scientific and medical discussion of love can certainly be viewed as uncovering new ways in which love can be fascinating and interesting to us, it can be seen as involving another evaluative category mistake. It treats love as if it were mainly an object of study and purely theoretical interest, whereas love is usually mainly valued as an object of desire and practical interest.

Conclusion: Narrow and Broad Conceptions of Human Well-Being

Should we conclude that love and love relationships are wholly separate from health and well-being? If we understand health and well-being in narrow ways, perhaps we should. That is to say, if we understand health as longevity and the absence of disease and well-being as pleasure and an absence of depression, love can indeed function as a potent cause of health and well-being. But love is then not an intrinsic part, or essential element, of health and well-being themselves. There are,

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however, conceptions of human health and well-being within philosophy and related fields that are broader in nature. Some of these are conceptions under which love and well-functioning love relationships are understood as core components or elements of health and well-being, or of "human flourishing."

Let us quickly consider just two examples of such broader conceptions of well-being: (1) the one developed by Martin Seligman within the field of "positive psychology" and (2) the one developed by the economist Amartya Sen and the philosopher Martha Nussbaum for the theory of social justice and human development studies. Positive psychology, as Seligman defines it, is the empirical study of human flourishing and its causes and correlates.[22] The conception of well-being that Seligman operates with is encapsulated in his acronym "PERMA." *P* stands for positive emotion, under which Seligman collects all purely subjective aspects of health and well-being, such as pleasure and life satisfaction. *E* stands for engagement, which, among other things, is supposed to capture what is sometimes called "flow." *R*—which is most important for our present topic—stands for positive relationships, including love relationships. *M* stands for meaningful activities, and *A* for accomplishment. Within this PERMA model of human well-being, love is not mainly regarded as a means to health and satisfaction. Rather, it is treated as one of the key elements of human flourishing.

Consider next the "capabilities approach" developed by Amartya Sen and Martha Nussbaum. Under this way of theorizing human well-being, we enjoy well-being to the extent that we possess and are able to exercise a certain set of distinctive human capabilities. Capabilities are defined as effective abilities and real freedoms to exercise particularly important modes of human functioning.[23] The idea is that, if we are not in possession of these human capabilities, we cannot be said to be in the possession of a rich and fully dignified human life.[24] And among the capabilities that Sen and Nussbaum argue are essential to human well-being, things such as bodily integrity (which includes health, as Earp et al. understand it) and the capacity to experience positive and satisfying emotions (hedonic well-being) are only two entries on the list. Just as in Seligman's PERMA model, the capabilities approach also understands love and love relationships as being among the essential human capacities and modes of functioning that are distinctive, and irreducible, elements of what it is to thrive as a human being.[25]

These are just two examples of the wider conceptions of human health and well-being we can find within the different fields of study that concern themselves with these topics. There are also other broad conceptions of well-being going all the way back to Aristotle's notion of "eudaimonia" (an understanding of happiness that helped to coin the term "human flourishing"). The point here is not to explicitly endorse any of the just-mentioned wide conceptions of human health and well-being. The point, by way of conclusion, is instead as follows.

The arguments of the foregoing sections are not meant to wholly divorce love and love relationships from considerations about health and well-being, as if these belonged in wholly different spheres of human thought and concern. The idea is rather this. Suppose we want to conceive of promoting love and love relationships as a way of promoting health and well-being. Suppose also that, at the same time, we want to be sensitive to the particular sort of value, and the distinctive status, that love is usually given within human life. If so, then it seems

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to be a good idea to adopt broader conceptions of health and well-being than those used in Earp, Savulescu, and their coauthors' articles on the biomedical enhancement and medicalization of love. Love, we can then say, is indeed something that promotes health and well-being. But that is so because love is itself among the core goods that people seek and treasure for their own sakes. It is because love is one of the essential components of human flourishing, that is, of health and well-being in richer senses of these terms.

If we think of the relation between love and human well-being in this wider way, however, the following happens. It becomes unclear, or at least an open question, whether we really could promote love—and thereby promote health and well-being in a broader sense—by means of biomedical enhancements. Because if we want to (1) think of love as a core element of human flourishing and (2) do so in a way that is sensitive to the modes in which people typically value love, then we must conceive of love in the manner in which people normally think of it when they seek love for its own sake, as a goal in itself. And under the associations and ideas with which people normally value love, it is not altogether clear that we could deliver this distinctive good into one another's hands by means of gene therapies and hormonal drug treatments.

People desire to be able to inspire love in their partners simply by being the particular people they are.[26] They desire that their bond should continually be strengthened and deepened as an ongoing result of the developing shared histories that they build together within their loving relationships.[27] They desire to find that their lovers are a good match for them. If, in contrast, the attachments our "lovers" have to us need to be initiated and sustained with the aid of biomedical enhancements, is it really love that we are receiving from our partners? Or would it rather be some other kind of attachment, which might perhaps be positive and desirable in its own ways, but which wouldn't really qualify as love under our common conceptions of what love is? Those are further questions[28] we need to discuss before we can settle the question of whether a medicalization of love is something regrettable, or whether it perhaps is a prospect we should welcome in the way that Earp et al. do.

Notes

1. Marshall AG. *Make Love Like a Prairie Vole*. London: Bloomsbury; 2012.
2. Savulescu J, Sandberg A. Neuroenhancement of love and marriage. *Neuroethics* 2008;1(1):31–44.
3. Persson I, Savulescu J. *Unfit for the Future.* Oxford: Oxford University Press; 2012, at 120.
4. See note 2, Savulescu, Sandberg 2008, at 42.
5. Quoted in Parens E. On good and bad forms of medicalization. *Bioethics* 2011;27(1):28–35, at 33.
6. Earp BD, Sandberg A, Savulescu J. The medicalization of love. *Cambridge Quarterly of Healthcare Ethics* 2015;24(3):323–36.
7. See note 5, Parens 2011.
8. Fisher H. *Why We Love: The Nature and Chemistry of Romantic Love*. New York: Henry Holt; 2014.
9. Earp BD, Wudarczyk OA, Sandberg A, Savulescu J. If I could just stop loving you: Anti-love biotechnology and the ethics of a chemical breakup. *The American Journal of Bioethics* 2013:2–17, at 7.
10. See note 6, Earp et al. 2015, at 325.
11. See note 2, Savulescu, Sandberg 2008, at 34.
12. See note 6, Earp et al. 2015, at 326–31.
13. See note 6, Earp et al. 2015.
14. See note 5, Parens 2011, at 2.
15. Scanlon TM. *What We Owe to Each Other.* Cambridge, MA: Harvard University Press; 1998, at 99.
16. See note 15, Scanlon 1998.
17. Mill JS. Utilitarianism. In: Robson JM, ed. *Collected Works of John Stuart Mill*. Toronto: University of Toronto Press; 1963:203–59.
18. Cf. Book 1 of a work by Marcus Tullio Cicero: Cicero MT. *On Duties*. Cambridge: Cambridge University Press; 1991.

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19. See note 6, Earp et al. 2015, at 332.
20. See note 6, Earp et al. 2015, at 332–333.
21. I discuss this last point at greater length in Nyholm S. Love troubles: Human attachment and biomedical enhancements. *Journal of Applied Philosophy* 2015;32(2):190–202.
22. Seligman M. *Flourish*. New York: Free Press; 2011.
23. Sen A. Capability and well-being. In: Nussbaum M, Sen A, eds. *The Quality of Life*. Oxford: Oxford University Press; 1993.
24. Nussbaum M. *Creating Capabilities*. Cambridge, MA: Harvard University Press; 2011.
25. See note 24, Nussbaum 2011. Cf. Nussbaum M. Human functioning and social justice. *Political Theory* 1992;20:202–46.
26. Protasi S. Loving people for who they are (even when they don't love you back). *European Journal of Philosophy*; forthcoming.
27. Kolodny N. Love as valuing a relationship. *Philosophical Review* 2003;112(2):135–89.
28. See note 21, Nyholm 2015.

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