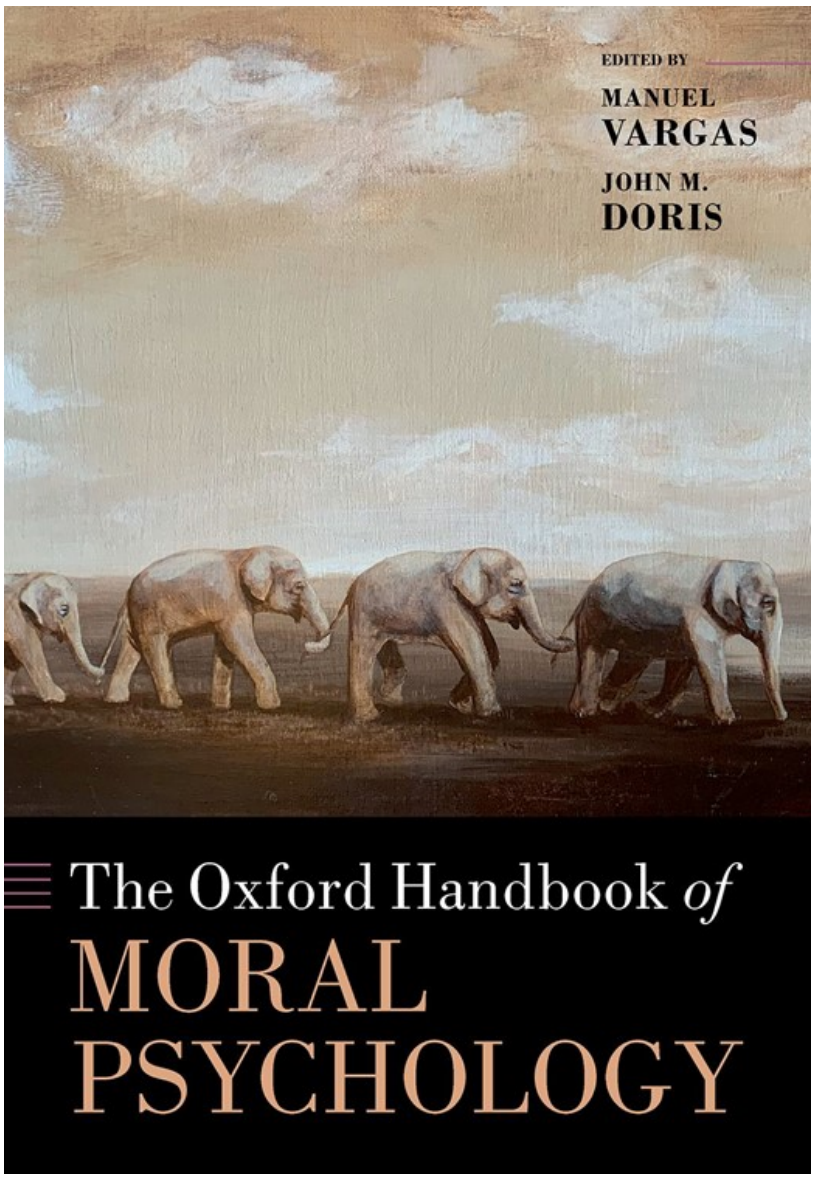

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CHAPTER

44 Agency in Mental Illness and Cognitive Disability

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Abstract

This chapter begins by sketching an account of morally responsible agency and the general conditions under which it may fail. We discuss how far individuals with psychiatric diagnoses may be exempt from morally responsible agency in the way that infants are, with examples drawn from a sample of diagnoses intended to make different issues salient. We further discuss a recent proposal that clinicians may hold patients responsible without blaming them for their acts. We also consider cognitively impaired subjects in the light of related issues in moral and political theory, asking whether they have been unjustly excluded from liberal conceptions of political community due to their presumed lack of agency.

Keywords: agency, blame, cognitive disability, moral responsibility, Pickard, philosophy of psychiatry, social contract, social model of disability

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44.1 Introduction

AGENCY is the capacity we ascribe to agents, who act in a way caused by their own mental states. It is important in many philosophical domains, most notably in discussions of freewill and moral responsibility. To exercise agency, or to be a fully formed agent, is widely recognized as a hallmark for the appropriateness of moral evaluation. Schlosser (2019: §2.1) gives an account of a standard picture of agency, according to which:

> a being has the capacity to exercise agency just in case it has the capacity to act intentionally, and the exercise of agency consists in the performance of intentional actions and, in many cases, in the performance of unintentional actions (that derive from the performance of intentional actions).

This is quite a minimal conception of agency, which may include any organism capable of purposive behaviour. Philosophers tend to be interested in a richer notion of agency which makes agents suitable objects of moral appraisal. Such agency involves the ability to discern and respond to reasons, although specifying what that involves is no easy task, as we note in §44.2. Human adults are paradigmatic agents on this picture. Human infants, substantially lacking in the capacity for intentional action, are not agents but become agents over the course of their psychological development. And of course, even healthy human adults fail to exercise agency on occasion. Whatever underlies intentional action, distorting factors like sleep or intoxicants are commonly understood to undermine morally responsible agency. This suggests that psychopathology, as another distorting factor, can affect agency by robbing someone of the capacity to act as an intentional agent. As philosopher John Doris has recently put it,

> Uncertainties of psychiatry notwithstanding, there are frequently obvious differences between clinical and healthy populations, and some of the most important differences, it seems to me, are appropriately marked as differences in self-direction: healthy people control their behavior and order their lives in ways that many sufferers of mental illness cannot. If that's right, normal ↳ and pathological psychologies can sometimes be distinguished along dimensions of agency.

> (Doris 2015: 34–5)

We will say more about this idea in a moment, but the basic worry is that certain mental illnesses or cognitive disabilities can render individuals unfit targets for judgments of moral responsibility. In this chapter we will chiefly be concerned with those states of mind that might cause failures of moral agency. We will trace some of the ways in which such failures occur, and discuss their significance and their possible amelioration. Throughout, when we refer to 'responsibility', we have in mind specifically *moral* responsibility (as opposed, for example, to mere causal responsibility).

Some of the disputes we look at have the following shape: an agent looks to be engaged in purposive behaviour that meets the thin conception of agency we borrowed from Schlosser, while lacking some other qualities that make them suitable objects of moral appraisal in a stronger sense. In some cases, the details might turn out to be empirical. For example, the mental states that motivate OCD sufferers to engage in their rituals are sometimes seen as contentless responses to stimuli—mere habits that push agents around. Claire Gillan (2017) thinks of them as habits, and theorizes habits as directly elicited by stimuli which let us perform tasks on autopilot without being driven by higher-order goals. If OCD sufferers act due to such habits, they might not, when acting like that, be intentional agents in a strong sense. (For a philosophical defence of a different subpersonal account, see Cochrane and Heaton 2017.) On the other hand, as Robert Noggle (2016) notes, OCD involves what look like quite sophisticated contentful states of mind:

> anxiety that some dreaded state of affairs might come true, along with motivation to take suitable precautions. Moreover, the compulsive motivations typically bear a clear relationship to the content of the obsession. Persons with contamination obsessions experience motivation to wash. Persons with obsessive thoughts about disasters occurring because of unlocked doors or improperly flipped switches tend to check them.

The natural interpretation, thinks Noggle, is that these states are 'quasi-beliefs': belieflike states that lack some of the characteristics assigned by folk psychology to fully fledged beliefs, but nonetheless a lot like beliefs in their relation to behaviour. If this is correct, perhaps people with OCD are agents in as full-blooded a way as moral philosophers could want.

All this to say that it may be that in some cases the issues we address will be resolved by scientific development. In other cases they may be more conceptually intractable.

We begin in §44.2 by examining morally responsible agency more closely, and discuss the general conditions under which it is said to fail. We provide a brief argument that individuals with psychopathological diagnoses (such as those found in the DSM-5) are not thereby exempt from the realm of morally responsible agency in the way that infants are. Then we will examine how and when different psychological conditions or variations undermine the exercise of agency. We do not aim to look at all the possible conditions that one might wish to discuss. Rather, we try to look at a sample of diagnoses that make different issues salient. We go on in §44.2.1 to discuss how practices of holding individuals responsible may be modified in light of these conditions by referring to a recent proposal that clinicians often hold patients responsible but do not blame them for their acts. In §44.2.2 we end by considering agents with
p. 895 cognitive impairments, and ask not whether or how they should be ↳ held responsible, but whether they can be provided with social and environmental resources and opportunities in ways that compensate for their impairments and enable them to exercise agency.

44.2 Morally responsible agency: what is it?

If anything is uncontroversial in philosophy, it is the claim that causal responsibility is insufficient for moral responsibility, and that just doing something does not make an agent out of the one who does it. In other words, not everything you do is something that you are morally responsible for. Indeed there are some entities, non-human animals for example, who are capable of acting in the world but do not count as morally responsible at all. We might punish an errant dog or seek to modify its behaviour, but that is not the same as holding it morally responsible. Although dogs look as though they act with a purpose—she sits and begs because she wants the cheese—we don't consider dogs to be agents in *this* sense. Being an agent, then, depends on properties that humans have and dogs lack. Acting as a morally responsible, normatively competent agent must require some certain cognitive accomplishments. That is to say, getting it right morally involves complex psychological capacities just as much as getting it right when doing mental arithmetic reasoning or finding the right word to express a shade of meaning.

Getting it right qua moral agent depends on having 'a complex capacity enabling the possessor to appreciate normative considerations, ascertain information relevant to particular normative judgments, and engage in effective deliberation' (Doris 2002: 136; cf. Wolf 1990: 124, 129; Watson 1993: 126–7). Grasping and acting on normative considerations must involve not just motivational structures that impel us to act, for dogs have those too. It must require neuropsychological structures that are generally implicated in recognizing affordances, deliberating, and initiating actions which result in behaviour in one's environment.

We do not know the nature of these systems in enough detail to make justified assertions about how they work, and there is much dispute over whether they should be seen as affective or cognitive, or both (or something else). But it would be startling if moral agency did not rely on the sorts of cognition involved in decision-making more generally. Normal decision-making rests on a host of executive, memory, and attention systems, and many others. While there are many complications and controversies relating to philosophical theories of moral responsibility, we will proceed with what we hope is a (relatively) uncontroversial observation: morally responsible agency is made possible by the successful operation of these systems.

44.2.1 When does agency fail? Excuses and exemptions

Any one of the psychological systems involved in agency might misfire, collapse, be overridden, or
p. 896 otherwise fail in the performance of a particular behaviour. As we have ↳ suggested, moral conduct depends on cognitive organization, and this provides a way to make sense of a familiar picture of normative assessment by distinguishing two modes of failure, *excusing* and *exempting* conditions (e.g. in Wallace 1994: 118).

Excusing conditions obtain when agents with the right intentions, who would normally be held responsible, nonetheless act in circumstances that make it unreasonable or unfair to hold them, in those circumstances, to otherwise applicable moral demands. Cases of coercion and ignorance are familiar examples. You do not have a chance to act as a full agent if you are unaware of your behaviour or its consequences, or if you have no acceptable alternatives. As P. F. Strawson writes, in these cases we are inclined to excuse with such phrases as ' "He didn't mean to", "He hadn't realized", "He didn't know" [...] "He had to do it", "It was the only way", "They left him no alternative", etc.' (Strawson 1962: §4).

Exempting conditions obtain when we find that a putative agent lacks the psychological capacity needed to actually be an agent at all, such that it would generally inappropriate to hold them to moral demands. Young children are a familiar case. An individual with such a status is viewed as exempt from the realm of morally responsible agency, either at the time of a particular behaviour or all of the time; they may perform a

harmful act but not be held responsible for it. In these cases we are inclined to exempt by saying things like ‘ “He’s only a child”, “He’s a hopeless schizophrenic”, “His mind has been systematically perverted”, “That’s purely compulsive behaviour on his part” ’ (Strawson 1962: §4).

44.2.2 Psychopathological diagnosis as exemption

As is clear in Strawson’s language, severe mental disorder and cognitive disability are routinely proposed as examples of exempting conditions (cf. McKenna and Kozuch 2015). But care should be taken here. It is not always stressed enough that these factors can come in degrees—a person with moderate cognitive disabilities might be capable of understanding why it would be good to make their bed or show up for work on time, but fail to appreciate reasons for other actions. The relevant factors may also be temporary rather than chronic—a depressed person might not understand reasons for action that would be accessible if she were not in a depressive episode; or local rather than global—some disorders, such as circumscribed delusions, seem to enable people to act on complicated chains of reasoning, but starting from premises so outlandishly delusional that neurotypical people would reject them out of hand. Conditions can vary then with respect to both degree and domain when it comes to lack of agency. We can also ask about the environmental conditions which support morally responsible action—cognitively or developmentally disabled people may be able to act as agents only if the environment, both physical and social, is accommodated to their needs.

Due to these complexities, we lean towards the *nuanced* view of agency in mental illness, allying ourselves with philosophers Josh May and Matt King:

> The diversity of ways in which the symptoms of mental disorders affect action makes them an extremely heterogeneous class, such that there is no supported general inference from having a mental disorder to any claims about one’s moral responsibility […] There is no reason to believe that having a mental disorder generally makes one less responsible than those who enjoy better mental health.
>
> (May and King 2018: 14)

p. 897 May and King contrast their nuanced view with the naive view, which states that mental illness affects individual responsibility without qualification: if you fit a diagnosis, then you are less of an agent. But the nuanced view is not actually all that nuanced; in effect, it denies that mental illness or other cognitive impairments are, qua diagnoses, relevant to assessments of agency or responsibility at all. The relevant unit of assessment is an agent in a context. Some individuals may, in a given context, suffer from a relevant impairment, but this could just as easily be a temporary state that is not due to a clinical condition at all: you might not be depressed, but just broken-hearted. It is the symptoms, King and May insist, rather than the condition, which matter for agency. We take it by this that they think that the mere label tells us nothing, and maybe diagnostic labels cover a diversity of symptoms. They come quite close, in the text just quoted, to denying that there are any genuinely exempting psychological conditions at all, although it is consistent with their view that there exist symptoms that are enduring enough to count as exemptions.

So, a nuanced view need not insist that there are no cases where an individual’s condition is so severe that we should exempt them altogether from the realm of morally responsible agency. There may indeed be cases of severe psychosis or cognitive disability which rob individuals of all such title. But the fact is that a diagnosis itself does not reliably track this extreme situation. We agree with King and May that we should not, therefore, default to considering individuals with psychopathological diagnoses as non-agents in the way that infants are. The damage of a false negative in understanding something as a candidate for moral agency should be considered far more ethically problematic that that of a false positive.

44.3 The excuses and exemptions of psychopathology

Illness can excuse a person from moral demands. If a powerful bout of food poisoning restricts you to the bathroom all evening, it would be wrong to blame you for failing to meet a friend at the airport as you promised. What sociologists term 'the sick role' (Parsons 1951) excuses you from some normative demands, but not all of them; no matter how profound your food poisoning, you are not off the hook for murder. And the sick role also imposes some distinctive obligations: you may be required to try to get well, for instance.

Transient yet acute disruptions that temporarily impede agency also appear in the psychological domain. Examples might include an unexpectedly strong reaction to a psychiatric medication, a dissociative episode, a short-lived acute manic episode, or a brief psychotic disturbance. Kozuch and McKenna (2014) are concerned mostly with cases of this sort, in which mental illness acts as an excuse rather than an exemption. They note an important qualification, however. In the case in which gastric circumstances beyond my control mean I can't meet you at the airport, Kozuch and McKenna argue, I am not completely excused. There remains what they call 'the moral residue' of my original commitment. I should take steps to inform you of the problem, maybe, or make alternative arrangements, insofar as I can; the severity of the case matters. In their example, Jane's anxiety disorder may overwhelm her to the point that she says
p. 898 something cruel to a co-worker. If in her anxious state ↳ she genuinely could not help herself, she is excused. Jane's agency has been undermined in this case. But because she is only excused, she remains a moral agent, with a moral agent's more global responsibilities, including what they call the residue. Kozuch and McKenna argue that the episode does not cancel out Jane's residual moral obligations, as might happen if she sank into a chronic condition. Insofar as she can discharge those obligations later, or remain aware of them, they think she should. Jane is therefore not excused, once she has regained control, from apologizing or otherwise making amends

On the other hand, as we noted above, there are cases of severe cognitive failure which are straightforward exempting states. We do not blame the floridly psychotic or utterly senile for their acts because these are states which disrupt, or perhaps temporarily obliterate, the executive, memory, attention, and even sensory systems which underlie intentional action. Further, contemporary medicine has not given us any easy or surefire means of preventing these states, by which we might attain a kind of indirect control over our own psychological capacities.

Unfortunately, decision-making is complicated. Between florid psychosis and a momentary loss of control, there are myriad ways in which things can go wrong. The question then is when, and to what extent, a particular psychiatric condition can cause an agency relevant system to misfire, collapse, or be overridden in an excusing or exempting way. Can an OCD sufferer be 'constrained', for instance, by a compulsion in a way that excuses compulsive behaviour as the effect of an internal impulse that overrides any intentional control? Perhaps instead we should think of agents acting under a compulsion as exempt? Is *every* failure to be explained by individual variation in executive function? Indeed, it is quite possible that our neuropsychological underpinnings go astray in such diverse ways that our customs do not track them clearly, and we cannot unreservedly say that one is or is not an agent in the requisite senses. Shoemaker (2015) calls this marginal agency 'cases at the boundaries of our interpersonal community where agents tend to strike us as eligible for some responsibility responses but not others' (p. 4). In the following sections we will look at some of these possible cases.

44.4 Addiction and decision-making

Heyman (2009) argues that addiction is a failure of rationality rather than a disease. He resists the picture of alcoholism as a brain disease like Parkinson's or Huntington's in favour of a seeing it as a pattern of often irrational, but basically normal, decision-making, noting that alcoholics and other addicts often face a 'local v global' dilemma that they resolve via a motivated false belief.

Consider: like anyone else with a decision to make, an addict facing a choice between using a drug and doing something else needs to evaluate the options. For someone who feels in dire need of self-medication or mood-altering, the utility of using may outweigh the utility of not using; after all, it's only one drink, or bet, or pill. But if one makes this decision over and over again, the utility of using may be much lower than that of abstaining. The local decision is to drink now, whereas the global framework is to see episodes of drinking as part of a larger self-destructive pattern. Heyman suggests that addicts often reframe the
p. 899 decision ↳ to use so that it counts as a special case, an exception to the overall pattern, thereby turning it into a one-off decision rather than an episode of local vs global conflict:

> The following list will likely sound familiar: 'It's a special occasion … It's just this one time … My friends are here only for one more weekend; when they go I will stop drinking so much … It's the last time. Tomorrow I'll turn over a new leaf … It's a once in a lifetime chance,' and so on.
>
> (Heyman 2009: 131)

This reasoning preserves normal decision-making, but still accounts for problem drinking. If this picture of addiction is right, then the addict does not fail to weigh reasons appropriately. (See Ainslie 2001 for a classic discussion of self-defeating behaviour.)

However, as Heyman acknowledges, the belief the addict calls on to justify reframing their choice is very unlikely to be true. It's *not* just this one time. And resolving a dilemma via a motivated false belief is *seriously* irrational if any choice or act whatsoever gets justified by counting an untruth as true. Suppose (to take an example we owe to Gabriel Segal) that you would prefer to stay at home and watch the game but you know that you risk serious consequences if you don't show up at work. You can resolve this difficult choice by converting your inconvenient old belief about needing to go to work into the belief that you won't get into trouble if you play hooky. Now you have no countervailing reason to offset staying at home. You can just settle into your favourite chair and start yelling at the ref. But even though that may resolve your dilemma, it is hardly an example of successful decision-making.

Heyman's position seems to rely on a key assumption that chosen behaviour cannot be pathological; it may be a violation of rational norms but not a symptom of an undermined psychological capacity. This seems hard to accept. For a belief to justify a decision or course of action, it has to be hooked up to the world in some acceptable way. It doesn't have to be true, but it must be in some way well-founded. The capacity to form well-founded beliefs and avoid ill-founded ones is a capacity which might systematically fail in a way that undermines morally responsible agency, and it may be that some cases of addiction are underpinned by failures of this kind, perhaps by undermining self-awareness. For instance, in contrast to Heyman, Segal (2013) regards the core symptom of alcoholism, qua disease, to be a disordered reward system in the brain that causes irresistible urges; it is the contents of the alcoholic's representations that are pathological (pp. 309–10). These representations tend to persist, and can have quite broad effects on decision-making; it is common ground in this debate that being an addict can cause choices other than using to be less attractive (going out for a walk is less attractive if you feel terrible because you are an addict). So, if alcoholism or other addictions genuinely are examples of chronic pathological decision-making due to differences in the reward system, they offer plausible examples of exempting conditions. They erode agency because of

decision-making abnormalities. We will now discuss another putative example of exemption, due to epistemic rather than decision failures.

44.5 Delusion and decision-making

We have discussed theories which suggest that some pathologies are disorders of choice. Now we discuss the
p. 900 extent to which we can admit so-called pathologies of belief into our ↳ understanding of agency. After all, a self-aggrandizing bias that causes one to form the belief that 'this time, it'll be different' has a different flavour entirely from a persistent paranoid delusion. If you kill your neighbour because you think they are a government robot assassin in disguise, then there is a sense in which you have successfully chosen a course of action. If the government has sent robo-assassins after you and it's your life or theirs, then your actions might be justified. But your decision-making reflects a distorted view of the world—on the face of it, your beliefs are formed wrongly enough to cast your sanity into doubt. Again, it is not the ability to *appreciate* reasons that is the source of trouble for your ability to act as an agent, but the *kind* of reasons you are prepared to countenance. It seems possible to have a belief and act on it in a way that mimics ordinary, unexempted agency, but for one's belief to be acquired in ways that are *not* reflective of morally responsible agency.

Or consider a patient with Capgras delusion who thinks that his father has been replaced by a robot. Suppose, as has really happened (Burgess et al. 1996), he then tries to justify the belief to others by sawing through the neck of robot-Dad in order to expose the wiring within. On the one hand, this looks like good instrumental reasoning; it will show the sceptics, and one doesn't have to worry about the well-being of the robot. On the other hand, something has clearly gone wrong at the first step. In this case, the patient's problem, to begin with, is that agency relies on cognitive innards that in this case are simply not engaged with the world in the right way.

Intention also seems to have a similar structure to belief in this respect. Suppose you have tickets to a concert you really want to attend and have agreed to attend your brother's wedding at the same time. You can desire to be in both places at once without breaking any norms of rationality—because desires aren't subject to the same kinds of assessment—but you can't seriously *intend* to be in both places at once.

In contrast to these cases, profound psychosis, which can cause widespread failures of this sort, is often seen as a paradigmatic exempting state. Circumscribed delusions are trickier. People with circumscribed delusions are capable of instrumental reasoning about many topics, but suffer from grave problems in a limited range of thoughts that touch on the subject of their delusion. We might say that these people are not normal agents, or we might think of them as normal agents with a specific handicap that exempts them from responsible agency in some contexts. To think of such cases as excuses, though, gets the facts wrong; these are not temporary or externally imposed deficits but chronic ones, stemming from changes in the cognitive systems on which agency depends.

44.6 Failures of will

For some diagnoses, it appears that agency is undermined not by a failure in reasoning or in basic inference mechanisms, but by a failure in control over behaviour once a judgment is made. In the classic example, the unwilling addict describes their behaviour as a 'slip' or 'against my will', saying moreover: 'I couldn't help it.' (For more on these alternative models of addiction, see Levy 2006; Sripada 2017.)

As we noted earlier, compulsive behaviour is also often described this way by its sufferers (Segal 2013). It may easily be imagined that a person acting under a compulsion is exhibiting perfectly rational behaviour

p. 901 under the circumstances—the visceral psychological pain of ↳ *not* washing one's hands or checking the lock a certain number of times is far higher than the cost of just going through with it. But there also seems to be an interesting sense in which an actor is literally unable to stop. Some subjects with Obsessive Compulsive Disorder (OCD) or other tic disorders describe losing an internal battle: wanting to stop, knowing one should stop, trying to stop, and yet not stopping.

Generating positive internal motivation is sometimes described this way as well. A depressed person, rather than failing to appreciate the reasons for getting out of bed, fails to be motivated by them. (For a harrowing first-hand account, see Solomon 2001.) You want to get up, but somehow you are still here. In these cases, it seems there is a local disconnect between the affective mechanisms that provide motivation and the capacity to direct one's behaviour in the moment. The very fact that an individual experiences an atypical or perhaps debilitating amount of pain or distress in an everyday situation like brushing one's teeth and getting out of bed can be agency-undermining in a manner similar to instances of external coercion—again traceable to the workings of an affective psychological mechanism.

The warrant of affect comes up in other diagnoses as well. Anxiety- and stress-related disorders are characterized by 'inappropriate' emotional responses to everyday situations. We don't want to make claims about what justifies any particular emotion here, though it is worth noting that affective states like anxiety can inhibit goal-directed behaviour in an excuse-like way, where the agent is not exempt from more global moral responsibilities.

Finally, it is worth considering more global types of control. For those struggling with Attention Deficit Hyperactivity Disorder (ADHD), it is not the capacity to stop or start a particular action that is generally the problem, but the capacity to direct one's attention and effort over an extended period of time (Sripada 2019). Still, we should hesitate to exempt someone with ADHD from the realm of morally responsible agency. Consider: if I average 50 per cent of free-throw shots, it would be strange to say that I am off the hook for five of the ten I made in a particular game, and even stranger to say that no particular success or failure adheres to me. Even if it were impossible for me to improve through practice, my shots are my own, hits and misses alike. Still, it also seems unfair to hold me to the standards of the likes of, say, Steve Nash, a 90 per cent free-throw shooter. Similarly, the ADHD individual may be excused for a particular lapse in attention but, like the anxious and depressed, not be exempt from the greater set of responsibilities that come with moral agency.

44.7 Cognitive disability

It seems clear that, in addition to the psychiatric diagnoses we have already discussed, there might be other many mental and physical conditions that can impede or affect agency, especially those which have more global or developmental effects. In this section we look at diverse intellectual conditions that are normally treated as disabilities.

We know that our discussion of disability alongside pathology will strike many theorists and activists as improper, so we should begin by clarifying what we are up to in this section. To discuss disability alongside cases of pathology or others forms of impairment might seem to adopt the 'medical model' according to which a person with a disability is in some way physically or mentally impaired relative to the healthy norm for humans. Medical-model adherents judge disability to be like a disease, a morbid state or process that is
p. 902 judged to ↳ 'divert part of the substance of the individual from the actions which are natural to the species to another kind of action' (Snow 1853: 12). This view holds that people with disabilities, like people with diseases, are rendered worse off in virtue of these functional impairments, and the explanatory burden of their disadvantage is borne chiefly by the failure of their physiology or psychology to do what is 'natural to the species'. A concept of disability as dysfunction is at the bottom of this way of looking at things, and it

has been resisted by rival pictures of disability that have made headway in philosophy, as elsewhere, in recent decades (see e.g. Barnes 2016 for an extended philosophical discussion).

We do not mean to side with the medical model against other conceptions of disability. The spirit of this discussion, instead, leans in the opposite direction, inviting us to see cases of mental illness as inhabiting the same treacherous normative terrain that has been well discussed in the philosophy of disability. (Indeed, one of us has previously written against using a concept of dysfunction as a delineating concept in psychopathology (Washington, 2016).) Also, most of what we have to say will be consistent with any interpretation of cognitive disability; our interest is in the significance for theories of agency of non-neurotypical states in general. Due to these complexities, it is worth setting out the terrain briefly before we proceed.

A widely shared response to the medical model of disability is that disability is not a pathology at all. Disability, according to this rival 'social model', is analogous to features like sexuality, gender, ethnicity, and race. The scientific basis for this position appeals to the idea that 'the partitioning of human variation into the normal versus the abnormal has no firmer footing than the partitioning into races. Diversity of function is a fact of biology' (Amundson 2000: 34). The social model arose via promotion by disability activists who define disability as 'the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities' (UPIAS 1975, quoted in Shakespeare 2010).

According to the social model, disability is not a departure from normal or healthy human functioning which makes an atypical condition a 'bad difference' from the norm; rather it is a 'mere difference' (Barnes 2016). The variation present in disability is an important part of human diversity, and should be cherished rather than eradicated; insofar as the lives of people with disabilities are bad, or worse than others, it is due to society's treatment of them, rather than disability itself. The fact that a life lacks some feature that other lives enjoy does not make it worse or harmful. Any one of us would resist the idea that our lives are less good because they lack any one particular joy … that of religious communion, for example, or the pleasure that comes from doing the kind of advanced mathematics that hardly anyone can manage. A person who needs to use a wheelchair will obviously suffer if the environment is not configured properly, but on the social model it is the environment, not her lack of mobility, that is the problem. Barnes thinks that there are many ways to explain the badness that usually goes with disability without adopting the 'bad-difference' view which holds that disability exists in virtue of a bodily impairment rather than a bodily difference. For example, disabilities might be caused by bad events (wars, injuries), and people with disabilities might be worse off than they would be if they could satisfy desires that are impeded by their disability. Of course, everybody can endorse the claim that some, or much, of the badness attaching to lives like these stems from the failure of social institutions and physical environments to be configured in ways that promote justice for
p. 903 them. Proponents ↳ of the medical model can certainly agree that people with disabilities suffer ill-treatment in virtue of their disability, even if they think that disabilities are genuine medical impairments.

It would take a long and not fully relevant discussion to develop these rival positions comprehensively, let alone attempt to settle the debate, so we won't do that. We do, however, think that it is important to point out that whatever your preferred concept of disability might be, it would have the consequence that people with disabilities suffer impediments to agency. Where intentional action is undermined, stymied, or made more difficult, so too is agency. One might argue that even if cognitive differences are not intrinsically bad, even mere differences might diminish the capacities necessary for agency, especially in some environments. However, there is a possible response, namely that this shows our existing philosophical conceptions of agency are ableist. Something like this response, as we will see, has been offered in political philosophy, to argue that the standard liberal conception of the individual is tied too closely to the mature, cognitively and physically non-disabled, adult.

Our concerns in this chapter relate to intellectual or cognitive disabilities. Some scholars sympathetic to the social model worry about its applicability to intellectual disability (Shakespeare 2010; Shakespeare and Watson 2002), and this reflects the concern that agency is more fundamentally impaired in intellectually impaired people than it is among the physically impaired. If someone is physically disabled, they may find themselves unable to act effectively if the environment is antagonistic; a wheelchair user cannot get to a job interview if stairs are the only option. But something like that is true for everyone: a non-swimmer cannot save a drowning child if the water is too deep. Environmental or bodily contingencies may make it impossible to act effectively, but they do not render somebody a non-agent. Intellectual disabilities, though, seem to deprive someone of what it takes to be an agent. Is intellectual disability an excusing or exempting condition? Does it render one morally non-responsible?

Shoemaker (2009) takes up the case of what was then still known as mild mental retardation (MMR: IQ of 50–69). Perhaps a word about the terminology is advisable. The *DSM 5* (American Psychiatric Association 2013) relabelled 'mental retardation'—the label previously in use—as 'Intellectual Disability' (pp. 33–41). The traditional cut-off for Intellectual Disability is two standard deviations below the mean for IQ, meaning about one person in forty meets the diagnosis. The 2013 discussion (p. 37) also notes the limitations of IQ as a measure of intellectual function, especially at the extremes. The diagnosis also includes deficits in the practical and social domains; roughly, the practical domain encompasses self-care and capacity for independent living, whilst the social domain is a matter of how well you can navigate social life (including the regulation of your own emotions).

Shoemaker approaches intellectual disability from the perspective of Watson's (2004) distinction between attributability and accountability. Adults with MMR (mild intellectual disability) have matured to a point at which emotional interaction with them is mostly straightforward. They are susceptible to what Shoemaker calls 'emotional address': you can make them see that they have hurt someone or crossed a moral line. Therefore they may be held to account. On the other hand, attribution responsibility may be inappropriate for people with MMR. Insofar as responsible agency is a cognitive feat requiring one to grasp moral concepts and requirements, Shoemaker argues, it may be beyond the moderately intellectually disabled.

However, there are different types of injury, and some injuries may not be understandable without
p. 904 apprehension of quite subtle or abstract concepts. It may be possible for me ↳ to understand that I have made you cry, but not grasp exactly why I have made you cry. An intellectually disabled individual (or anyone else) may not be up to absorbing these subtleties. They may be left aware that another is angry or distressed and aware that they have committed an injury, but still be in the dark about what has caused the other to feel injured. In such cases, holding them to account seems unjust, and this suggests a connection that Shoemaker wants to nullify, between the emotional sensitivity and maturity requisite for accountability, and the cognitive sensitivities that make attribution apt. As we noted, the *DSM 5* discussion takes all these capacities into account.

Now, if we think of mental disability as making some kinds of moral claim against one comprehensible, and others not, we seem to arrive again at the idea that membership in the community of moral agents comes in degrees because the cognitive capacities that determine membership in that community come in degrees. As mental capacities diminish, claims to fluent agency diminish with it. At the extreme, serious mental retardation, which is very rare, has been seen by philosophers as removing human beings entirely from the moral community and according them a status similar to, or below, that of other animals (Singer 1996; McMahan 1996).

However, this conclusion has been strongly resisted by other theorists. Eva Kittay (2009; 2017), in relation to her daughter, has expressed both personal repulsion at this view and a philosophical opposition to it based on non-cognitive attributes (such as response to music and a capacity for grief) that mean that a seriously mentally impaired human being remains a creature whose relation to us is quite other than that of

a dog. We are inclined to agree. Philosophers, who make a living with their minds, may overrate intellect as the important moral quality, even if it is necessary for agency. There may be specifically affective modes of response to our fellow humans that make us members of the community of moral agents whatever our cognitive capacities (Crary 2018 reviews the debate and argues this point forcefully).

This challenge, discussed at length by Nussbaum (2006; 2010), points to an unresolved political problem for philosophy: the social contract has always excluded non-agents, conceived of as the physically and (especially) cognitively impaired. People in Rawls's original position are asked to imagine themselves precisely as agents, and in doing so to ignore the features of human life raised by Kittay and Macintyre (1999). Not only are many cognitively disabled people not agents in the relevant sense, they, along with some physically impaired individuals, are also incapable of entering into a contract for mutual advantage. This is because they will never be in a position to reciprocate the benefits that the social contract is supposed to mutually confer on members of the body politic. Rawls indeed worried that some subjects would suffer from the distribution of natural assets. He assumed that deliberators in the original position 'want to insure for their descendants the best genetic endowment' and held that 'a society is to take steps at least to preserve the general level of natural abilities and to prevent the diffusion of serious defects.' (1971: 108).

This neglect of the disabled produces, says Nussbaum,

> a fiction [which] obliterates much that characterizes human life, and obliterates, as well, the continuity between the so-called normal and people with lifelong impairments. It skews the choice of primary goods, concealing the fact that health care and other forms of care are, for real people, central goods making well-being possible. […] More generally, care for children, elderly people, and people with mental and physical disabilities is a major part of the work ↳ that needs to be done in any society, and in most societies it is a source of great injustice. Any theory of justice needs to think about the problem from the beginning, in the design of the basic institutional structure, and particularly in its theory of the primary goods.
>
> (Nussbaum 2006: 127)

p. 905

Here, Nussbaum is concerned that adults with cognitive disabilities should not be stripped of the features of citizenship that embody equal respect for persons. This is true even if they need carers in order to exert a semblance of agency, and carers should be alert to the fact that even the most responsible agents have the right to goof off every so often. Any of us may occasionally wish, for example, to eat too many donuts and take a nap (Bannerman et al. 1990).

Nussbaum looks at a range of cases in which agency can be scaffolded or enhanced for the cognitively impaired, from those who are capable of (for example) serving on a jury but face obstacles to doing so to those who seem cognitively incapable of carrying out some of the offices that attach to citizenship. Some cognitive disabilities, like some physical ones, can be mitigated by changing the environment. So, we wouldn't accept that a wheelchair-bound voter can't sit on a jury because the courtroom was inaccessible, and we shouldn't accept that a person who is prone to anxiety or visual deficits should be denied a civic role if it is possible to change the situation in a way that enables them to participate without compromising the institution. Australian law, for example, bars deaf people from jury service, on the grounds that they may need an interpreter who would therefore need to be present in the jury room. But witnesses are allowed interpreters, and being deaf does not prevent one from weighing guilt and innocence. Nor are legal concepts harder to grasp in sign language than otherwise. It does not seem impossible to swear an interpreter to be bound by the rules of the jury room, even if it means a 13th person gets to sit there.

44.8 Responsibility without blame

Ultimately, we will have to ask ourselves a range of hard questions about how particular cognitive variations —whether construed as disabilities or illnesses—interact with different goal-directed actions. If, as we have suggested, failures of agency follow individuals in widely variable patterns, then we may even have to adapt our practices of holding agents morally responsible.

On the basis of these insights from psychiatry, Hannah Pickard has recently argued that we should resist linking the capacity to meet shared norms and demands on the one hand and being the appropriate target of praise and blame on the other. According to her, responsibility should be attached to the normative capacities that a person has, but detached from moral praise and (especially) blame (Pickard 2011; 2013).

Examining clinical practices, Pickard notes that clinicians often report that they hold their patients morally responsible for norm transgressions even though blame is considered inappropriate, and that many therapeutic strategies involve holding patients responsible, bringing them to see themselves as responsible for their harmful actions, while being careful not to blame them. On these strategies, clinicians encourage their clients to take responsibility for bad behaviour, for instance by identifying with it, making reparations
p. 906 for it, and learning better ways of conducting themselves. This is seen as central to treatment, whereas ↳ blame—the act of explicit negative evaluation—is regarded as detrimental to the patient's future prospects. Effective treatment, therefore, seems to require holding patients responsible without blaming them.

Pickard notes that these clinical stances often relate to personality disorders, which in some cases are explicitly conceived of in moralized terms (Charland 2004; Pickard 2011: 210). Borderline Personality Disorder is the classic example. It involves extreme and inappropriate anger toward the self and others, instability in self-image and interpersonal relationships, and marked recklessness, impulsivity, and paranoia. Borderline patients—indeed, patients with personality disorders generally—are notoriously hard to care for (in both senses). They may manipulate and bully their carers. Clinicians and other carers tend to assume that borderline and other PD patients know what they are doing and are responsible for the trouble they cause, unlike individuals with psychotic conditions engaging in the same behaviour. The latter are typically seen as acting in ways they cannot control. PD patients are not. They are held responsible, but blaming them is seen as bad practice and as likely to worsen treatment outcomes. Pickard (2011: 214) sees this as a sort of 'trap'. If patients with PD are treated as normally responsible agents, the apportioning of blame will do substantial harm. But the cost of treating them as exempt is also less effective treatment, because it becomes hard to get the sufferer to become a partner in self-transformation. Pickard regards responsibility without blame as the way round this difficulty, and reports that it happens frequently in clinical settings.

The solution is not that clinicians do not regard the transgressions of PD as blameworthy, but that they withhold what Pickard calls 'affective blame', which is not just a judgement of blameworthiness but a suite of 'negative reactions and emotions that the blamer feels entitled to have' (2011: 219). Clinicians can achieve this by regulating their responses and by keeping in mind the histories of their patients and clients, in effect summoning up empathy to counteract the natural tendency one feels to engage in hot emotions when one is entitled to blame another. It's not that the clinician can't make a judgment of blame, but the blame must be detached from emotion, rather as if one were contemplating a distant historical event.

Pickard claims that these clinical practices challenge broadly Strawsonian theories of moral responsibility by challenging the connection between being responsible and deserving blame. Strawsonian theories form our framework here, and are very much the mainstream view in contemporary moral psychology. What's distinctive about these theories is their tight link between an agent's being responsible and that same agent being an appropriate target of attitudes that praise or blame them for their conduct. As we noted above, some entities may be exempt, on either a temporary or permanent basis, as moral agents because of the

sorts of thing that they are. But entities that do count as moral agents seem to be proper targets of moral evaluation.

This raises interesting issues about agency. The normal case is that responsibility and blame go together as a hallmark of agency; agents are responsible, and in virtue of that they can be blamed. Put another way, the aptness of blame just is the hallmark of responsible agency. In cases of responsibility without blame, it might seem that we are dealing with non-agents, but Pickard is clear that the sort of responsibility she has in mind, though less than moral, is in important respects agentic (2013: 1140). PD patients and others are not just causally responsible in a way that a falling tree could be responsible for smashing your roof.
p. 907 Patients are often acting out or relieving stresses, and lack insight or other means of coping. ↳ Pickard argues that our reactions to them—or at least the reactions of the relevant clinicians and carers—should track the same underlying capacities that we normally track with respect to responsible adults, while remaining detached from the responses that usually accompany that tracking.

Responding to Pickard, Daphne Brandenburg (2018) agrees that we need to revise the Strawsonian link between responsibility and blame, but denies that the concepts have to be as dissociated as Pickard seems to want. The core of Brandenburg's reply is that in these cases the attribution of responsible agency is not tracking what it would normally track. She argues that we have here a practice that tracks, not full-blown capacities, but potential capacities. She argues (p. 8) that one can have the capacity to walk, and also the capacity to be a great leader, but in different senses. Most humans can actually walk, but very few are actually great leaders. Nonetheless, given the right instruction and environment, many of us could be. (We are unsure about this specific example, and would settle for the wide attainment of competent middle management, but the point holds.) To help someone become a leader, or to activate any other latent capacity, involves helping the person realize those capacities. This means that they should be treated as agents, but not as agents in possession of the capacities we wish to see flower within them. To do this, we need to hold them accountable for failures and setbacks, but also refrain from blaming them, because the shortcomings are the result of nascent capacities imperfectly regulated. Brandenburg calls this the 'nurturing stance'. In such cases our reactive attitudes respond to the presence of imperfectly realized capacities, by judging that a subject is a moral agent, but does not deserve blame. Instead, they warrant a different sort of response, one aimed at bringing these capacities fully online. Treating them as children—who offer similar challenges—would be improper, because they are not children, but imperfectly regulated adults. Like children, they are not blameworthy, but their different status is marked by holding them responsible all the same.

Brandenburg's idea gives advocates of responsibility without blame a way of responding to a possible objection. The objection insists that really all that's happening in cases of responsibility without blame is a kind of blame mitigation. Subjects are not being blamed as they would normally deserve because their conditions provide a kind of partial excuse. But both Pickard and Brandenburg stress the characteristic relation that carers or clinicians bear to the proper targets of responsibility without blame, in whom they try to develop the capacities for following the norms that the neurotypical live by. Carers must try to ensure that responsibility is attributed, because treating subjects as responsible is essential to their well-being going forward, but that blame is avoided, because the emotions that one should feel when one has done something blameworthy are very harmful for the subject. The stress is on affecting future behaviour rather than on evaluating past behaviour.

This debate, and some of our earlier examples, illustrate characteristics of many mentally ill or disabled people which can cause us to rethink the basic Strawsonian setup. Exempting conditions are often introduced via examples, with severe mental illness being a common case. But many people who receive a diagnosis are not in a condition that makes them completely ineligible for the attribution of responsibility. Instead, they have some underlying capacities that are hallmarks of membership in the moral community, while lacking others or instantiating them in rudimentary or partial ways. This might demand a kind of

response that doesn't fit the simple Strawsonian case. The implications of this, we think, are ripe for further philosophical discussion.

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44.9 Conclusion

In this chapter we urged a more nuanced view of morally responsible agency in mental illness. We argued that those with psychopathological diagnoses are not thereby exempt from the community of moral agents —rather, the extent to which an individual is in an excusing or exempting condition is variable, and dependent on the particular psychological, social, and environmental factors that underlie the exercise of agency or undermine it. So it is hard to arrive at a satisfying general theory rather than an array of more specific discussions of different conditions and problems. After looking at conditions such as addiction, delusion, psychosis, depression, and cognitive disability, we suggested that there is good reason to modify our practices of holding individuals morally responsible in some cases.

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