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# A Critique of Three Conceptions of Mental Illness

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This is an essay on the nature of mental illness. It begins with a discussion of some issues related to mind-body dualism and the views of Thomas Szasz. Following this brief dissusion, I consider three approaches to understanding mental illness which focus on the concepts of *abnormality, suffering,* and *disability.* The paper concludes with an interpretation of the social or ideological aspects of ascription of such concepts, especially those relating to disability.

More than anyone else in the last twenty years, Thomas Szasz has challenged the standard medical and social conceptions of mental illness, and in doing so has helped to encourage wide discussion of our conceptions of madness and the social control of deviance. But some aspects of his views have remained unclear, in particular those relating to the traditional problem of the relation of mind and body. Szasz never explicitly repudiates the mind-body distinction, but he does deny the distinction is an *ontological* or metaphysical one. Szasz makes reasonably clear that he does not hold that there are two things, bodies and minds, that constitute jointly a human being. He is too well versed in Ryle (1949) to take such a view. Yet he *does* want to maintain a distinction at the level of scientific discourse about human behavior. Emphatically, *not* everything about humans is adequately described or explained in the language of physics or the physical sciences in general. In particular, human actions call for a different account in terms of rules, roles, and practices. Thus Szasz (1961, p. 83) urges that "we shall not regard the relationship between the psychological and the physical as a relationship between two different types of events or occurrences, but shall rather consider it to be akin to two different modes of representation or language." This is true, Szasz holds, not only for the behavior itself, which can be understood as a symbolic process, but for the accounts of such behavior by someone else. And these approaches, "psycho- logical methods of investigation, and theory-construction appropriate to them, are scientifically legitimate, irrespective of the methods and theories of physics" (Szasz, 1961, p. 82). In particular, the relationship of mind and body is best understood, Szasz claims, in

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terms of "hierarchical organization, according to which physical organization is the most basic level, biological organization is superordinate to it, while psychological and social levels constitute increasingly higher orders of systems" (p. 103). Thus what Szasz objects to is the effort to reduce complex psychological and social phenomena to the language and terms of medicine and physics. It is not that they cannot be so described but rather that in doing so, the significance of the phenomena is lost in the account (Szasz, 1961, p. 91).

## Mental Illness and the Mind-Body Problem

There is good reason to hold that humans are biological organisms, but ones whose behavior permits and even requires a variety of descriptive and explanatory schemes whose differences reflect the hierarchical organization of human behavior. Szasz's efforts are aimed at showing that at the level of behavior characteristic of that cited as forms of mental illness, a "systematic theory of personal conduct" can be formulated which is "free of all reference to so-called primary or biologically given needs. . . . Our theory strives to eschew biological considerations as explanations, and instead attempts to construct a consistently psychological explanatory scheme" (Szasz, 1961, p. 230). This is not to say that such behavior takes place in "a neurophysiological vacuum" (p. 91). The problem is rather that *all* human behavior is biologically based: normal as well as deviant, sane as well as mad. It may be possible, of course, to discover some forms of behavior as due to physical malfunctioning of biological systems to some extent characterized independently of the behavioral symptoms. But then we would have an organic condition to deal with, a *physical* disease, injury, or change which is manifested by mental symptoms, and not a mental disease *per se*. If this were to occur in regard to some form of schizophrenia (p. 91), as it did in the case of paresis, then schizophrenia would cease to be a psychosis, or mental illness, and be rather a symptom of some underlying "physiological disorders in the human bodily machinery" (p. 81). Reduction of the mental to the physical *eliminates* the mental disease rather than clarifying its independently valid status.[1] If there is to be a category of mental diseases, it surely must be by virtue of a *contrast* with physical diseases and thus it must be the behavior, experiencings, beliefs, or desires themselves which are seen to be diseased, and not the universal biological foundations of all human life. But for human behavior to be "diseased," Szasz insists, is just for it to be deviant or abnormal or undesirable or bad, and in all these senses of "diseased" we are at best using the term metaphorically, for what is abnormal, deviant, undesirable, or bad in human behavior is a matter of social norms, not biological ones.

[1]See DeSousa, 1972, p. 192. This is an exceptionally lucid and thoughtful article from which I have learned a great deal.

There are *two* issues that need stressing here. One has to do with how we characterize the behavior or conduct of those labelled mentally diseased. The other is the relation of that behavior to the biological, especially physiological or neuro-physiological condition of such persons. Consider the second issue first. If we reject, as I believe we must, any version of mind-body dualism, then any mental disease, indeed any mental condition at all, must be a manifestation of some bodily condition, presumably of the central nervous system. In particular, a mental condition which we correctly deem to be *diseased* must correspond, it seems, to a physical condition which, were it known, would also be considered to be *diseased* in some correspondingly appropriate manner. (Or, of course, the diseased mind may correspond to a neuro-physiological defect or abnormality.) But the problem, as I have mentioned, is to avoid a *reduction* of the mental condition to the corresponding physical one. Otherwise, the mental disease is reduced either to the physical condition itself or to a symptom of that condition. The classical case, as I noted, is the discovery that paresis was not only a disease of the brain, but caused by the syphiletic spirochete (Flew, 1973, p. 77; Szasz, 1961, p. 81). How can this reduction be avoided if we presuppose a materialist or physicalist ontology? It must be by calling into question the correlation asserted above between mental and physical disease. Mental disease must be correlated with physical *conditions*, but, unless we beg the reductionist question, why must they correspond to physical *diseases* (or defects, etc.)? It must be, afterall, the mental condition itself which is diseased and not simply its correlation with a physical disease which leads us to characterize it as illness.

Our ability to treat the mental disease medically, i.e., physically, will depend on the discovery of ways to affect the mental condition through control of its physical causes. And this is equally true of mental conditions we do *not* consider diseased. Drugs, surgery, or physical therapy may equally enhance memory, say, as an aspect of learning, as they may diminish or control depression or phobias. Such a tack is forced on us by the fact that much of what has been considered as mental disease seems not to be correlated with any discernible general physical abnormality at all. And it was historically because of this that Charcot and other physicians concerned with madness came to distinguish between organic and functional illness. As Szasz (1961, p. 10) summarizes this development: "In medicine, the criteria for distinguishing the genuine from the facsimile—that is, real illness from malingering—were based first on the presence or absence of demonstrable changes in the *structure* of the human body. . . . The beginning of modern psychiatry coincided with a new criterion for distinguishing real from false disease, namely, *alteration in function*. Conversion hysteria was the prototype of so-called *functional illness*." When such functional alteration is voluntary, the prospective patient could still be considered to be malingering or faking, otherwise as a genuinely mentally ill person. (Of course, as Szasz [1961, pp. 11, 250-252] delights in recounting, the added ironic twist was that within a few years, persistent malingering was itself construed as a mental disease.) This is a

reasonable approach. Afterall, functional impairment or "alteration" is one of the criteria which signals the presence of a disease condition (though not, as Flew [1973, p. 65] suggests, the only one). And in this sense it is "epistemologically prior" to the concept of disease, mental *or* physical.

But we are now thrown back to the mad behavior itself. We cannot rely on known or unknown physical abnormalities, defects, or diseases as a causal explanation for behavior and as a rationale or justification for taking the *behavior* to be diseased. So we return now to the first of the two issues posed above: how to characterize the behavior itself. Three approaches are worth considering here. The first is that the behavior in question is sufficiently *abnormal* to warrant its designation as diseased. The second is that the behavior is accompanied by or is likely to lead to sufficient *suffering* to warrant being considered diseased. Both abnormality and suffering (as an undesirable feature of experience) are often taken as criteria of disease. The third is the idea of *alteration of function*, just mentioned, which I will construe as a manifestation of (mental) disability.

## Abnormality

Abnormality is a notoriously difficult concept. Its ambiguity stems primarily from its dual meaning of statistical infrequency, on the one hand, and of something bad and to be avoided, on the other. In the latter sense it is often synonymous with irrationality, for it conflicts with norms of rationality which are not usually clearly or even explicitly understood or acknowledged. What we must do is look at a variety of forms of behavior or experience in terms of this concept to see if they can be reasonably classed as abnormal in a sense that might warrant the further designation of disease or illness. There are four such cases—actions, beliefs, desires, and experiences—all of which may be seen as abnormal. The question is whether this may justify considering them, in a relevant sense, forms of mental illness or disease.[2] The justification will depend on discovering whether the notion of normality in these cases is close enough to that relating to physical conditions to clarify a metaphorical extension of the concept of disease.

There is wide consensus that the mere statistical infrequency of one's action, the uncommonness of one's belief or desires or experiences, is not, in and of itself, sufficient to mark these forms of conduct or experience as mentally ill or diseased. For one thing, it would imply that novelty as such was a sickness and that change and creativity in human life is suspect as such. There have been, of course, those who sought to stigmatize novelty and change as sick or diseased, but these very efforts have done most to discredit the concept of mental illness

[2]I rely here on the excellent discussion of these issues by DeSousa (1972), Flew (1973), and Culver and Gert (1982).

by being so clearly counter to what most people accept. For another thing, since under some description nearly everything can be counted as unusual, the designation of abnormality loses its significance unless it is part of a framework of theory or description whose justification or usefulness hinges on some broader conception of normality or abnormality. We must decide under what description an event is to be seen as unusual and this will depend on a choice of categories which we believe will illuminate the events in terms of some other sense of the normal or abnormal.

Consider first the question of belief. Some people seem to hold strange and even (to some) obviously false beliefs. This group of individuals may include religious or political fanatics, paranoids, and some whose beliefs seem just bizarre, deluded, or wildly irrelevant to the mainstream of accepted views. Clearly it is their unusual character that draws attention to such people and their beliefs. But it cannot be only this, for then we are merely noting differences in religious or political beliefs, degrees of anxiety or prudence or eccentricity as manifested by belief. It must further be because the beliefs are acquired or maintained in an unacceptable manner: without sufficient evidence or consistency, and so forth. But here we would be appealing to epistemic standards: standards of evidence, of consistency, of hypotheses formation. And these standards, not only disputed in themselves and undergoing constant change, seem not to pick out uniquely any belief or set of beliefs. As Nelson Goodman (1977) has argued, the projectability of predicates, the acceptability of hypotheses, is dependent on their entrenchment, their pedigree, which is a historically dependent fact about their previous use or their relation to other such predicates. It is a social and linguistic fact about them. Even granting a favored set of predicates, perhaps, as Peirce argued (Brown, 1983), based on evolutionary and biological factors, their application need not be unique. As DeSousa (1972, p. 195) notes "If the organism responds to relatively short sequences of observations with modifications of belief, he will learn fast but tend to be 'flighty' in his beliefs. On the other hand, if he responds slowly he will tend to be stubborn and insensitive to subtle changes in conditions. In the first case he will tend to mistake random variations in sampling for changes in nature; in the second he will make the opposite mistake. And what is 'just right' for some purposes will be wrong for others. There is no single optimum, and so no point of objective normality." Differences in standards, then, or the use of standards in acquiring or maintaining beliefs, scarcely seem an adequate basis for ascription of illness or a diseased mind.

But is not there a sense in which the belief or set of beliefs could be quite irrational? Consider the criteria of irrational beliefs recently proposed by Culver and Gert (1982, p. 38f). First, they are relative to particular persons: "A belief is irrational only if it is held by a person with sufficient knowledge and intelligence to know that it is false." But, second, it need not in fact be false; the belief need only be "contrary to the overwhelming evidence available to the

person and that he have sufficient knowledge and intelligence to evaluate this evidence." Third, the belief must be contradicted by the overwhelming evidence in a way that is "obvious to almost everyone with knowledge and intelligence similar to that of the person holding the... belief."

It may be that these criteria capture some cases of what we think of as irrational beliefs, including some delusions. But the problem with them lies in the third "feature." In order to avoid having to classify religious beliefs, for example, as irrational, they have in effect relativized the notion to particular groups. "We cannot call religious beliefs irrational if they are in fact held by a number of people." But what peers should we accept as sufficiently or relevantly "similar" to the person holding the belief to use as a standard of what is "obvious"? And is it mere numbers that count? (Did Jim Jones cease to be paranoid or delusioned because so many agreed with him? Was the entire group irrational—a view seemingly rejected by Culver and Gert?) We might ask further whether the determination that "amost everyone" disagrees with the believer is an empirical matter, and if so, how this would be determined. By a poll or survey? How many must share my belief to protect it from charges of irrationality? Perhaps there are lone believers, stubbornly clinging to views all others like them have abandoned or never held, or even those who hold beliefs which others cannot consistently share (see Rokeach, 1981). But these must be rare indeed. Furthermore, Culver and Gert argue that a belief may gradually "become irrational as evidence accumulates against it." Presumably by the same token a belief may gradually cease to be irrational as evidence accumulates for it. Yet they argue that "a paranoid schizophrenic does not cease to be irrational if, quite fortuitously and completely unknown to him, someone *is* plotting against him." But suppose it *does* become known to him (and indeed people do plot against paranoid schizophrenics)? Does he cease to be irrational? As I will argue later, this is not clear.[3] Surely, too, there are cases of belief against overwhelming evidence accepted by nearly everyone else, which though stubborn or spiteful or recalcitrant, we hesitate to label irrational. Priestly clung to a belief in phlogiston all his life and Einstein resisted the vagaries of quantum mechanics in spite of repeated failures to show that its statistical character was eliminable in favor of some non-statistical construal. But suppose someone ignores or refuses even to consider conflicting evidence? But this, too, is not enough. Boredom, indifference, neglect, spite, may—and for most of us does—provide such cases. To those who bother to reflect on the evidence it may be obviously a false belief. But few may bother. In cases where they do reflect, because of the importance of the belief (its link to potentially harmful or beneficial actions, for example), we must count on others to weigh the balance of harm and benefit. How often is such weighing likely to be "overwhelming" or apparent to "everyone"? Indeed, Culver and Gert admit that "some religious

[3]In fact Fried and Agassi (1976) argue that the answer must be no.

and political beliefs can convert almost any seemingly irrational act into a rational one" (p. 23).

Does all of this mean we cannot spot an irrational belief when we hear one? No, not at all. But it casts doubt on our arriving at a fully general account of irrationality or abnormality, and points to the relevant standards as fundamentally social and normative. Indeed, most beliefs are arrived at and shared not on the basis of evidence or argument but by virtue of psychological and social factors involving our membership in or exclusion from various social groups and practices. Indeed those beliefs most often cited as delusionary are of just the sort least amenable to evidential warranty and most likely to fall under subrubrics as religious, mystical, political, or metaphysical, but not under those of biological, medical, sickness, illness, or disease. There seems little, therefore, in the beliefs themselves, however crazy, to warrant the designation of sick or diseased, except that some or even nearly everyone may reject them as contrary to evidence, good sense, current views, or community consensus, and none of these considerations seems at all like those that would be adduced to determine the presence of a physical illness or disease.

Deviant or abnormal desires or wants seem to raise similar issues. It cannot be the case that mere deviance of wants is sufficient to warrant consideration of someone as diseased, sick, or ill. Many people have unusual or rare sorts of desires, preferences, and inclinations, and entire groups of people may have wants quite different from those typical of other groups. To designate some of these as diseased or sick because they are different or unusual risks a relativizing of mental disease to person, culture, society, or historical epoch which would make the notion scarcely distinguishable from an expression of parochialism or prejudice or moral disapproval. But some desires and wants seem, even within a given community, to be so bizarre or strange as to warrant a more extreme judgment. Here again, what seems to be crucial are the norms or standards by which we assess such wants. By and large, desires and wants are assessed in terms of the actions they motivate. A desire for committing an evil or immoral act will be repudiated as such and perhaps itself be characterized (or the person who has it) as evil or immoral. But clearly judgments of morality are radically different from judgments of sickness or disease. But actions can also be irrational and the desires which lead to them may also be characterized as irrational. This is the approach of Culver and Gert (1982) who explicitly define an irrational desire as a desire to carry out an irrational action. I will have more to say in a moment about irrational actions, but for now it will suffice to indicate that they go on to define an irrational action as one which "consists of harming onself" (or increases "the probability of self-harm") "without an adequate reason" (pp. 26–27). An adequate reason is a conscious, future-directed rational belief "that one's action will (probably) help oneself or someone else to avoid or relieve some evil or to gain some good." The balance or ranking of harms or evils is to be one that rational persons would accept. They would have to rank the

evils likely to be avoided by the self-harm as equal to (as great as) or presumably greater than the evils caused by the self-harming action itself.

This account of irrational action seems to capture some cases we clearly want to characterize as irrational. The cases cited by Culver and Gert include self-mutilation or suicide, which are based in part on irrational beliefs or on mood changes which may be transient, however momentarily powerful, as motivating factors. But, as a general account, the Culver and Gert approach seems inadequate. There are too many other cases which fit their account, but whose acceptance as irrational runs counter to common usage and, more importantly, tends to disparage desires and actions which are more commonly accorded tolerance and even respect. For example, many people participate in sports which have a high probability of debilitating injury or even death, but which may have little or no compensating gains: rock climbing, sky diving, boxing, or even football, and especially, perhaps, "dare-devil" activities. The motivations here seem primarily the risk of danger itself, the thrill of facing likely danger. Religious desires, again, may count as examples: self-mutilation, sacrifice, penance, all may involve severe self-harm based on desires which many would not count as irrational. Similar are political actions of self-sacrifice, self-immolation, or imprisonment as protest, or even death as opposed to alternative political arrangements. The slide here form the bizarre to the greatly imprudent is barely perceptible. Yet the risk, even likelihood, of self-harm is not something we can easily assess or even be sure when we can with justice condemn. And that assessment will inevitably bring us back to questions of belief which, as we have seen, fail to provide a cogent basis for attribution of mental disease. However difficult it is to specify the full range of the rational or irrational, it seems clear that such concepts are fully evaluative and imposed in the context of social standards and practices. Furthermore, even when belief or desire have been characterized as irrational, it is clearly insufficient warranty for the further designation of disease or illness.

Much the same, as was said of beliefs and wants, can be said of those states in which people show few if any wants at all. Depressed moods in which an absence of desire (or a desire for death—a total absence of experience altogether) can often be construed as responses to circumstances which permit or even require evaluation as rational or appropriate, sensible, relevant, intelligent, meaningful, etc.—all evaluations whose standards are clearly social and normative even if in some cases nearly universal. The fact that such moods and states can be altered pharmacologically and may even sometimes be caused by known biological abnormalities, does not change the situation. The moods and states must *themselves* have already been determined to be diseased or sick, and this is just what is in question.

## Suffering

Suffering often accompanies behavior and is often suggested as a criterion or a symptom of behavior that should be classed as diseased or sick. Often such suggestions are made in an indiscriminate fashion, failing to specify what is meant by suffering and under what circumstances it may be expected to occur. Culver and Gert, for example, multiply the kinds of suffering which they associate with "mental maladies," but narrow the circumstances in which they occur. Thus the suffering must occur "in the absence of a distinct sustaining cause," i.e., the suffering is not one that will readily disappear if the social or physical environment changes, but rather one that is due to the condition of the person, not the person's environment. Deviant behavior, for example, often produces distressing clashes with other people, but were this interpersonal clash to end, the behavior itself may involve no suffering. Similarly, someone may be depressed by circumstances of death, failure, or other reversals of life's fortunes, but it is only when such moods do not respond to changes in these circumstances that they appear to be "endogenous," due to the condition of the person and not a response to "distinct sustaining causes" (p. 81).

Culver and Gert also enlarge the kinds of suffering one may experience as a result of such behavior (indeed, actions are characterized by them as irrational just in case they tend to produce such a range of suffering). These include "death, pain, disability, loss of freedom or opportunity or loss of pleasure." To some degree these features of their definition are at odds with each other. Afterall, the evils which people are apt to suffer if they are depressed, anxious, or sad are to a considerable extent due to social environments which are "distinct sustaining causes," not perhaps entirely of the feelings or moods themselves, but of the risk of further experience of harm.

Culver and Gert's views are also ambiguous as between the claim that it is certain dysphoric states themselves that are being judged as maladies (because they are *instances* of suffering psychological or mental pain) or rather other "conditions" which may lead to such mental suffering or other harms. In the latter case, when delusions, gradiose ambitions, disregard of others' feelings or rights, recklessness, etc., are not themselves experienced as instances of suffering, the risk of harm is primarily due to interpersonal conflict and secondarily to the physical environment. Indeed, it is well known that the suffering that leads to determination of mental illness and subsequent confinement is often that of people not themselves so labelled or confined. In any case, as we have seen, evaluations of such risk is a matter of social standards which fail to isolate any narrow category of behavior which is plausibly deemed diseased or sick on analogy with the cases of physical or biological disease or illness. But what about cases of mental suffering themselves? Surely Culver and Gert are right in classifying such pains as in and of themselves "bad things, that is, things to be avoided" (p. 71). Were they to occur in this isolated way, without distinct

sustaining causes or accompanied by other feelings and beliefs, etc., surely we would seek to end them. It may be that our calling such feelings diseased or sick is an indication, as DeSousa (1972, p. 196f) suggests, that they can be eliminated by medical procedures, such as the use of drugs, to effect a change in hormonal imbalance or serotonin levels, in short, because we seek to change the physical conditions that cause them. But nothing seems to be gained here by labelling the feelings themselves as diseased, anymore than in other cases where physical diseases produce behavioral, perceptual, or affective symptoms which can plausibly be considered mental.

Much of the problem here is that the conditions we are discussing, though they are frequently called symptoms, are not in fact symptoms of anything. Insofar as they are symptoms, they are indications of underlying physical abnormalities and hence not themselves diseases or illnesses, but part of a larger disease entity that does indeed call for a medical or biological response. Indeed, the curious thing about so-called mental diseases is that the disease and its symptoms collapse into each other. Mental illnesses, if they are anything, are apparently *only* symptoms. But here "symptoms" has little of its usual meaning as a sign or indication of some abnormality or disease condition. And as we have seen, efforts to determine in what sense the mental condition—behavior, desire, belief, etc.—is itself abnormal or diseased, permits of no easy answer, and such as seems plausible leads us to look at social standards, not medical or biological ones.

There are, of course, further problems. Not all cases of bizarre behavior or desires or beliefs are accompanied by suffering or mental pain except as due to interpersonal or social interaction, and some socially accepted, even encouraged, behavior, beliefs, or attitudes may be accompanied by anxiety and distress, depression, or feelings of low self-esteem. Striving for success, efforts at creative work, bigotry, sinfulness, etc., all may involve dysphoric feelings.

Part of the problem with our analysis so far has been our concern with particular sorts of deviant behavior, wants, or feelings, or even tendencies and inclinations toward such behavior, and though such behavior may be relatively irrational, undesirable, "disfavored" or painful, it was not for that reason plausibly characterized as diseased or sick. The norms involved appear to be social, not medical, and the counter examples or exceptions indicated that the features of such behavior are not ones that fully satisfy our intuitions about illness and disease. (And it is precisely the broad sweep of any such labelling of behavior that Szasz has correctly criticized. In seeking to catch the mad, our net has brought in far too much and thereby cast doubt on the entire effort. Furthermore, the mesh has clearly been not just too narrow, but perhaps not even tied correctly.) What is missing? Where have we gone wrong?

## Ability

The most cogent response to these questions must be to look for features of disease or illness elsewhere than at the level of abnormality or suffering. And the most likely candidate seems to be *alteration of function*. But not mere alteration so much as *dysfunction*, and this in the particular sense of *disability* or *incapacity*. Moreover, the disability or incapacity must be *mental*, not physical, in order for it to provide a useful criterion for mental disease or illness.[4] (However, even here the analogy tends to break down. If "mental illness behavior" involves a loss of ability, e.g., in addiction, say, then it is not a disease, but an impairment, or perhaps an injury. Ill feelings, such as anxiety, may accompany the disability, but largely due to external social and environmental conditions.) It will be useful to suggest here what we might mean by "mental disabilities or dysfunctions and then consider more carefully the idea of a disability itself. I have already implicitly delineated the mental to a variety of intentional states of persons, including wants, desires, beliefs, and emotions and feelings; and, as we have noted, one's behavior and actions, insofar as they are intentional perhaps, are plausibly seen as manifestations of the mental. (And if we accept the Freudian notion of the unconscious, we enlarge the sphere of the mental to include unconscious intentional states as well.)

What then about the notion of an ability or disability? Ability seems to me to be the more basic concept. It is typically in contrast with what people *do*, and hence with what they are *able* to do, that we consider what people cannot do.[5] The crucial assumption here is clearly that some deviant behavior is transient, controllable, within the voluntary control of the person so behaving, whereas other cases, those properly considered symptoms of mental disease, manifest a

[4]Culver and Gert (1982) offer an alternative criterion: "one talks of physical pain and disability when and only when some particular part of the body, other than the brain, is necessarily involved in suffering the pain or disability. (When the brain is clearly involved, such as in a brain tumor or lesion, we usually speak of both mental and physical disabilities being present.) If the pain or disability is not restricted to a particular part or parts of the body, then we speak of it as mental pain or mental disability" (p. 88). This seems to work in some cases, particularly dysphoric feelings of anxiety, dread, etc., and for some disabilities. But it fails for those classical cases of hysterical conversion reaction which set the stage for much of modern psychiatry. For such cases precisely *do* involve some particular part of the body, even "necessarily"—otherwise they would not be conversion reactions. True, no physical disorder or abnormality is usually found; but it is "symptom" that Culver and Gert focus on, not etiology. Since "conversion disorders. . . can involve sensory disabilities. . . or motor disabilities" (which are physical disabilities), they seem not to know how to classify them.

[5]The notion of disability has been widely used by philosophers and others as a key to analyzing the concept of a mental disease or illness. Flew (1973) makes it the defining characteristic of disease: "the disease, if it is to be a disease, must be defined: not in terms of the mere inclination towards the disfavored behavior: but in terms of an inability to inhibit that inclination" (p. 66). Herbert Fingarette, in a series of distinguished essays on criminal responsibility, has long claimed that "disabilities of mind" are the key notion to explaining what aspect of irrational criminal behavior may exculpate those charged with criminal offences. See, for example, Fingarette (1976).

loss of control and therefore constitute a dysfunction or alteration of the mind itself, a diseased condition which renders the person not immediately responsible for the corresponding symptoms. In this sense, a mental disease or illness just *is* a mental disability or incapacity which manifests itself in bizarre, irrational or deviant behavior. Such behavior itself may lead to a variety of harms for such persons, but it is by virtue of the disability which is thereby manifested that such harmfulness may signal the person's condition as sick. The core concept then in such an analysis of mental disease, and correspondingly of madness, is that of mental disability or incapacity. Let us see what credibility such an account may have.

First, a number of clarifications and distinctions are needed concerning the concepts of ability and disability. A basic beginning distinction is clearly between my being able to perform some action and my being inclined to do it. I may be perfectly able to ride a bicycle, but not want to. I may prefer to go for a long run and my not cycling would not be evidence that I am unable to. By and large, however, an attribution of ability "typically serves to deny that some particular preventive circumstance obtains" (Scheffler, 1965, p. 93). I am able to cycle if the derailleur on my bicycle has been repaired, or the flat tire fixed, and such claims indicate that what might have prevented my riding does not prevent it. We can refer to such factors as the circumstantial factors that determine ability and say that I am able to do something when the circumstances are appropriate or the standard ones for such actions. (Such circumstances must include, of course, temporal references to the action in question. I cannot ride my bicycle at this minute because it is not here; but I am able to do so at some earlier or later time.)

There are some circumstances, however, which seem so intimately connected with the agent that some writers have indicated them as relevant to a special set of abilities which have been called basic physical abilities. These are a subset of our ability to perform certain basic actions. Basic acts are intentional acts caused by an agent's wants and beliefs which require no previous act to occur. My paying my bill may require my signing a check which requires my moving a pen in a certain way. But all these actions seem "generated" by or derivative from the more basic act of moving my arm and hand. Although other things occur as necessary conditions to my moving my arm—nerves fire, muscles twitch, etc.—these are not things I normally control, need know about, or ever need intentionally to activate in order to move my arm. Physical acts are one kind of basic act, the other kind, which philosophers have said little about, are mental acts which I can perform at will: thinking about yesterday's bike ride, imagining winning the Red Zinger race, etc. Of course, I may be prevented from performing some basic act by various circumstances of the sort already mentioned, but also by constraints or injuries which limit my freedom. I cannot move my finger if it is tied down or broken or anesthetized; I cannot think of riding my bike if drugged, distracted, or asleep. Furthermore, not everyone can exemplify the same sort of acts at will. I can wiggle my ears; perhaps you cannot.

Our repertories of types of basic acts may be different. The ability to perform such kinds of acts seems different from the kind of *circumstantial* ability mentioned already. It is more nearly an *"absolute"* ability. Indeed, J.L. Austin (cited by Goldman, 1970, p. 64) argued that such ability is unconditional: not all "cans," he said, are "constitutionally iffy." But for various reasons his argument no longer seems persuasive and we can analyze ability (what we *can* do) in a conditional sense. Roughly, for someone, S, to be *able to do* an act of a certain kind, A, at some time, t, is:

> S is in normal circumstances at t and A is a type of basic act for S.

And we can define a *basic act* as follows:

> A is a type of basic act for S at t only if: if S is in normal or standard circumstances at t, then if S wanted to do an act of type A at t, then S would do such an act at t.

A variety of different versions of this analysis is possible, substituting for "wanted" such locutions as "tried," or "desired," or "chose," or "willed," the crucial point being the assertion of a "reliable connection" between the wanting or trying, etc., and the doing (Davis, 1979, p. 44; Goldman, 1970, p. 62).

Given such a notion of ability, it is clear that different persons have different repertoires of basic abilities, abilities to perform a certain range of basic acts. Some persons have, some lack, the ability to wiggle their ears, run a sub-four minute mile, solve differential equations, etc. But though someone may *lack* a given ability, it is not therefore appropriately designated a *disability*. We could call an inability a lack of ability common to everyone, a lack which is characteristic of the species, say, or a lack which is due to one's not having some special training (Culver and Gert, 1982, p. 75f). In the latter case we may suppose that were someone given the training, one would be able to do the act in question; one could learn how to do it. Some kinds of acts, walking, for example, which seem basic to virtually all humans, we seem able to perform with a minimum of training or practice. Others require considerable training and effort; the learning process may be long and arduous. Some abilities seem more "basic" than others; they are abilities to acquire abilities. Most humans are born with such capacities as being able to learn a natural language, to walk, to tie shoe laces and button shirts, and so on. A few are not, and they are typically thought of as having a learning disability, or being physically or mentally retarded or impaired. We can think of a *dis*ability, then, as a lack of an ability which *is* characteristic of the species. We become disabled when we lose an ability which all or nearly all people have. But losing an ability we acquired by special conditioning or training, such as running very fast, is not a disability, though losing the ability to become a fast runner by training, due to an injury or disease perhaps, would be a disability. There are a number of qualifications which need to be mentioned.

For example, some abilities seem restricted to certain sub-groups of the species. They are relative to certain classes: females, mature adults, children. Other abilities seem to admit of degree and the deficiency which should count as a disability may be more a matter of decision than of any convenient gap in the distribution of the trait. By and large, however, the (rough) standard will be that the ability is possessed, to a sufficient degree, by virtually all members of the species in their prime. (The old then may progressively become disabled; the young, more abled with age.)

## Disability

We are now ready to consider the suggestion that a mental illness or disease (or impairment or defect) is a mental disability. We can consider the kinds of conditions mentioned previously—bizarre or irrational desires, beliefs, actions, or experiences—and add that they are indications of a disability rather than of an ability. It is not, therefore, the particular behavior which is appropriately thought of as sick or diseased; it is the underlying disability which the behavior indicates. Compulsive behavior is not so much the manifestation of a peculiar desire or want (to wash one's hands very many times a day) which we should tolerate, however harmful it may be to the person who does it, as it is a *lack of the ability* to restrain such a desire or to inhibit such behavior when it manifestly is harmful (by injuring one's hands and by limiting one's other pleasures and opportunities). Similarly, the phobic is someone who not only seems fearful of certain situations, objects, or places, but is relevantly disabled: he or she is not able to act in ways which may be clearly harmful and disadvantageous. The paranoid person not only possesses and acts on strange beliefs which, for all we know, may even be true; this much, as we have seen, we should tolerate on the grounds of epistemic charity. But the paranoid, too, seems relevantly disabled: he or she is not able to modify his or her beliefs in light of rational persuasion, argument, and evidence. Paranoid belief is not only fixed; it is incapable of being changed. Clearly what would make such disabilities significant is not only their (statistical) abnormality, but their undesirability, their likelihood of causing (serious) harm to those who have them. (By extension, if this approach is plausible, we could consider even disabilities which cause little or no harm or are even fairly frequent, to be mental illnesses of a minor sort.) To be mentally disabled, then, is to fail to have a mental ability which is characteristic of humans or at least of some relevant sub-group of humans, which moreover, is at least potentially harmful. And this is to say that for such a mentally disabled person a certain type of basic act is not in his or her repertoire.

To clarify these ideas requires that we specify the antecedent of actions so as to locate the relevant ability or disability. I have suggested that wants or desires are the (causally) relevant antecedents of our (intentional) actions and it is necessary to add that beliefs also figure importantly for many acts. Some things

that I want to do I can do only by doing other things and I must believe this in order to pursue them. My wanting to ride faster on the bike motivates my shifting the gears only if I also believe this other action will lead to greater speed. But this construal, while largely correct I think, is not accepted by everyone. Some writers on these topics hold that willing or volition is a necessary precursor to other actions, willing being itself a kind of very fundamental action (see Davis, 1979, p. 41). My own view is that what we mean by doing things "at will" is adequately explicated in term of wants and beliefs. Nevertheless, virtually the only effort to write about mental disabilities has been couched in terms of volitions, so I will examine this position before turning to wants and beliefs. If volitions are antecedents of actions they presumably are themselves the effects of various wants and beliefs and in turn cause those events, and other beliefs, which are correlated with actions. (Normally when I will to shift the gears, I do so [my action] and cause the gears to move [the correlated event] as well as my belief that I am doing so.) If we can clarify the idea of a volitional disability, then it must be related to this particular structure of human action.

What characterizes a volitional ability is the *joint* ability to will *and* not to will doing something (Culver and Gert, 1982, p. 112). The cases in question are best illustrated by compulsions and phobias. The compulsive person persistently willfully performs some action (say, hand washing), and yet seems not able not to will to do this. Conversely, the person with a phobia (say, for entering elevators) consistently wills not to enter the elevator, but seems unable to will to enter one. This behavior often persists even when such persons believe there to be very powerful ("coercive") incentives for acting otherwise, namely, the possibility of serious harm should they not refrain from the compulsive behavior or not perform the feared action (Culver and Gert, p. 111).

The first thing to note about such a disability—a volitional disability—is the striking *ad hoc* character of the concept. This seems to be due to its use in seeking to explain fairly specific sorts of behavior which are puzzling because they do not fit into our usual patterns of activity or come under our usual accounts of that behavior which seek to provide reasons of various kinds for it: motivations, purposes, causes, etc. So, to answer the question, "Why does S do A?" we can now reply, "He cannot help but do A; he suffers a (mental) disability." (In our cases a "volitional disability.") The problem here as with all *ad hoc* explanations is that we do little explaining. The disability is linked solely to this behavior, accounts for nothing else, and is tied to no overall theory of behavior which would broaden its scope or show in other terms that such disabilities are to be expected as part of certain broader patterns of human conduct. Its *prima facie* credibility, therefore, and its explanatory powers are from the beginning, highly doubtful. It is in part the specificity of the alleged disability that suggests its ad hocness, much as in the case of accounting for a drug's putting people to sleep by referring to its "dormitive virtue." Indeed it seems like a purely linguistic move to account for someone's not entering an

elevator to claim that the person lacks the ability to will to enter elevators. Or that someone's frequently washing his hands is explained by saying that he lacks the ability to will to refrain from washing his hands.

Nevertheless, some (but not much) sense *can* be made of such notions if they can be shown to fit into some larger scheme of dispositions and capacities whose interrelations can help account for the complexity as well as the variety of human behavior. In the case of opium, the move is quickly toward other features which are also linked to its dormitive virtue such as the drug's smell, taste, odor, and in more sophisticated contexts, a chemical analysis. As D.H. Mellor (1971) has written:

> It would indeed be too easy to explain a regularity in terms of a disposition solely constrained to account for it. Hence the notorious and exaggerated inadequacy of a drug's dispositional "dormitive virtue" to explain the sending to sleep of those who take it. We require therefore of at least the explanatory and explainable dispositions introduced by the sciences that they be linked to other properties and relations of the entity. Thus they are properly ascribable on the basis of other regularities than the ones they serve to explain. We have seen for example that solubility is ascribable on the basis of chemical constitution, and inertial mass is ascribable on the basis of weighing. A drug's dormitive virtue that was detectable also by smell or chemical analysis would be a perfectly respectable disposition. The links between dispositional properties that make them nontrivially usable in explanation are the laws which they enter, however loosely these may be formulated. (p. 65f)

Human dispositions or traits are not as invariably or neatly linked by empirical generalizations as are physical properties like solubility or dormitive virtue, though there are many common sense generalizations which function in a similar way. Hempel (1962), for example, in referring to what he calls "broadly dispositional" traits, remarks that such traits involve a

> complex bundle of dispositions, each of them a tendency to behave in characteristic ways in certain kinds of situations (whose full specification would have to include information about the agent's objectives and beliefs, about other aspects of his psychological and biological state, about his environment, *et cetera*.) (p. 18)

Though greatly limited, such generalizations are all we have. Still, they function in a very rough way to enable us to forecast behavior and more adequately to explain behavior when, after the fact, we have more information about the strength of an agent's desires and the focus of his or her beliefs and goals (see Goldman, 1970, pp. 73f, 107–109).

In the case of disabilities we can make several moves. One is to generalize. Does the inability to enter elevators extend to all small rooms, bathrooms, closets, automobiles, or only to elevators? Perhaps, too, the claustrophobia admits of degrees. Still, little has been gained in explanatory power by such moves. To the contrary, we may even defeat the claim. We are unlikely to ascribe a *physical* inability to enter an elevator to someone who has just walked across the hotel lobby to the elevator. Similarly, we would be equally reluctant

to consider someone as having a volitional disability to enter an elevator if he has just entered a bathroom, car, or foyer. Even in the case of one's failure to enter any small room whatsoever, we should begin to look beyond the general description of such behavior to the "complex bundle of dispositions" which make up the "quasi-theoretical connections," mentioned by Hempel (1962, p. 16), that give shape to one's life. That is, we must also consider the additional complex of wants and beliefs which jointly determine the orientation of behavior. Thus one's failure to enter an elevator may crucially depend on one's wants and beliefs, and not simply on a "volitional disability." The unusual nature of such behavior requires us to look for unusual wants and beliefs, such as a belief that elevators are dangerous and a desire to avoid anxiety and risk. Indeed with a consideration of wants and beliefs, it is doubtful that reference need be made at all to volitions. Wants and beliefs are themselves sufficient causal conditions of actions.

The concept of a volitional disability, then, though seemingly apt if we suppose that *willings* always precede actions, proves to be largely empty. And if we seek to relate it to other concepts, such as wanting and believing, to fill out our view of human agency, it proves to be unnecessary.

But now we can ask similar questions of these alternative (or additional) antecedents of action, wants and beliefs. We may ask whether a person who persists in washing his hands or virtually never enters an elevator has the *ability to want* to stop the compulsion or overcome the phobia, or whether the person has the *ability to believe* the relevant facts about the situations in question. Note that this construal of the issue differs from the earlier one in that it does not deal with the abnormality of belief or desire themselves, their "content," but with the ability to acquire and give up beliefs and desires. It is, in short, a second order cognitive or affective trait, one that might be adduced to explain deviant desires or beliefs or those that do, or seem likely to, lead to suffering or harm to the persons who have them.

However, it is not at all clear what sense can be made of an ability to want or an ability to believe. It cannot mean that my wants and beliefs are caused by prior events, since on any plausible accounts of beliefs and wants, *all* beliefs and wants, *or* the lack of them, are so caused (Goldman, 1970, p. 198). My not wanting to run a marathon may be caused by such events as my being disappointed by my previous efforts at this distance and by my having enjoyed cycling on past occasions which I intend to pursue instead of running. But this does not show that I am "unable" to want to run another marathon, it shows only *why* I *do not* want to. The fact that other wants are stronger than a given one and so lead to action, or that other beliefs rather than a given one lead to conviction, does not justify saying I could not perform some other action, or was incapable of other convictions. So my being *unable* to want or believe cannot be "regarded as coextensive with 'causally necessitated not to want'" or believe (Goldman, p. 198). Similarly, we should not confuse such an inability

with stubbornness, or slowness to learn with mental retardation. These traits have fairly clear criteria and seem distinct from the cases we seek to clarify by referring to mental disability. Furthermore, if there are such abilities, they are clearly not voluntary abilities to perform certain acts. I cannot typically acquire a want or a belief at will. I may want to desire to be more frugal, or want to believe in the good will of political figures, but wanting these things does not generally produce them. The reason seems to be that wanting or believing are not typically considered actions or acts at all; they are not species of basic mental acts. But our account of ability was in terms of what counts as a basic act for an agent. Insofar as a volition is a kind of action—willing is something I can be thought of as *doing*—it made sense to suppose that it is a basic mental act. But talk of an ability to will and not to will to enter an elevator or to wash or not to wash one's hands seemed to get us nowhere, and, in any case, was tied to an agent's wants and beliefs as well. Perhaps we can produce in ourselves certain wants and beliefs by doing something else. But failure here—and such techniques are widely acknowledged to be unreliable—is not a failure of belief or wanting, but of the other actions we perform to change our wants and beliefs. What we lack is knowledge of how to modify our beliefs and desires, assuming we want to do so, when ordinary means are not successful. Success is likely, moreover, when such purposes are consonant with our overall set of goals, attitudes and convictions, and in this case it is clearly persuasion, the weighing of evidence and the imagining of consequences which may lead to new wants and beliefs.

On the other hand, there is perhaps no question that I have a *general capacity* to want and to believe. There is no question simply because I *do* have wants and beliefs and they do sometimes change. Nothing has been added by referring to a general *ability* to want and believe, however. Even when someone manifests no wants and beliefs, it is open to us to construe this as itself a kind of choice based on unusual wants and beliefs. Many of my desires and convictions *do* lead to action or restraint. As in the case of physical ability manifested in one way while not in another, here, too, my capacity to form and modify my beliefs and wants in other circumstances may not be in doubt. In this case, our tactic will be to look for conflicting sets of beliefs or wants. Not all of our desires are mutually compatible, nor do our beliefs always comprise a coherent system, though we may seek such overall order and compatibility. Recognizing such complexity, however, may direct us toward efforts to reorder, compare, modify, or otherwise adjust our beliefs and wants to achieve greater coherence. Other things may be at stake, too. For example, though coherent, our beliefs and desires may lead to inefficient or degrading behavior which we could seek to change. But we have now returned to *assessments* of behavior, not a clear account of an inability to modify it. And the relevant kinds of assessment suggest a complexity in the antecedents of behavior which argue against a facile account in terms of some ready-made disability.

Perhaps we can think of the abilities in question as being on different levels. For example, when we are quite young we do not have the abilities to tie our shoe laces, operate a typewriter by touch, or crack an egg with one hand. But we do have the ability to acquire such abilities: we can (usually) learn how to do them. We can lose these abilities, too, in cases where frequent practice is required, or more rarely, from injury. In the latter case it is not the ability to type which is likely to be lost, but a whole range of skills, due, perhaps, to a broken wrist. The analogy here for the case of mental disabilities is not good, and, where similarities are apparent, unrevealing. We are considering something like an ability to acquire other more specific abilities. Is there an ability to acquire the ability to enter small rooms, or to desist from washing one's hands? Or an ability to want to enter small rooms, or to want to cease frequently washing one's hands? None of this makes much sense at all. Closer cases, however, may be those of depression and paranoia. Does a depressed person lose the capacity to want various things, and the paranoid person, the ability to believe various things about possible threats? These seem plausible, perhaps entirely by virtue of the analogy itself, for there is little else to go on. Not only is it difficult to say more about such abstract abilities to want or believe, at this level they have again an *ad hoc* quality which isolates them from larger explanatory contexts; and alternative explanations come readily to mind. Not to want many things may be due not to a disability of a wanting faculty, but to other, more austere wants to be left alone, to sustain grief, to cause distress to others. To believe in one's being persecuted may satisfy broader beliefs about the world, gratify one's pessimistic or sardonic outlook, or manifest allegiance to unusually stringent criteria of evidence.[6] We need, too, to consider that phobic or compulsive persons may share our views that failure to enter elevators, or to stop washing their hands *is* undesirable. They may, however, while wanting the ends we urge, reject the means available to achieve them.

We are led inexorably, then, to practical issues which further erode and cloud the theoretical value of attributing to such persons various disabilities. It is relatively easy to determine when someone *has* various abilities. Our evidential standards are not usually stringent. We estimate initial effort, are perhaps sensitive to learning curves, and finally gauge frequency of success. We need not crack the egg single-handedly every time, but only usually. The tossed peanut must land in my mouth only more often than not to achieve the admiring stares of my children. A high failure rate, among a fair number of tries, however, counts against the ascription of ability. But our cases are different. It is not *in*ability, but *dis*ability we are concerned with. Is not simply not doing something—believing the obvious, desiring the typical, behaving normally—

[6]My favorite example of ignoring such alternatives is that of Benjamin Rush, the "father" of American psychiatry. Rush attributed to those who did not believe in the utility of medicine or the truth of the Christian religion a "Derangement in the Principle of Faith, or the Believing Faculty" (Szasz, 1970, p. 143).

*prima facie* evidence of disability? It is not so simple. Not only are there logical problems of proving a negative claim, but the context of such behavior is not like others. There are no relevant disabling circumstances, no range of similar and related behavior which is also affected.

And so we enter here into the case history, a more or less detailed biography of prior behavior which sifts events seeking evidence for disability. We try to decide whether we can conclude that someone does not act, or believe, or desire, because he will not, or because he can not. And here even that he *will* not may be evidence that he *can*not. To be disabled in willing, wanting, or believing is to be unable both to will and not to will, both to want and not to want, to believe and not to believe. How much and what evidence shall we require? If "therapy" is effective—if someone now wants what was previously shunned, or believes what was formerly rejected, or declines what was formerly always chosen—has the disability vanished, been remedied, or removed, or was it afterall never there? If a chain smoker of many years suddenly stops smoking, was there no addiction (or disability to stop smoking) afterall? The recalcitrant, stubborn, foolish, stupid, slow, ignorant, passionate, and confused return as categories competing with the disabled in our efforts to characterize abnormal or unusual behavior. The rough and loose standards of evidence typically relied on for judgments of human traits require only that one *usually* do something or be *likely* to behave in certain ways—"ability is compatible with occasional failure" and disability with occasional success (Davis, 1979, p. 46). In such circumstances a variety of competing judgments may be equally plausible, and equally poor, in effecting a broadly explanatory account of behavior. Moreover, on any construal of human behavior, the complexity and subtlety of our lives cannot be ignored. It is especially important to attend to such complexity in just those realms of behavior where standard categories and patterns of judgment blur and waver.

What we need at this point, of course, in order to cut through the complexity, to interpret the variety, and bring order to apparent diversity, are theoretical considerations, that is, some broader explanatory scheme justifying, for example, attribution of disability to account for certain patterns of behavior. There is not much to choose from: psychoanalytic and behaviorist views (the latter of little help in that it eschews all reference to the mental in the first place) and more cogent, but less general, psychological theories like those of Tolman, Lewin, and others (see Goldman, 1970, chapter five). The problems are much the same for all such schemes. Theory in these cases is so undetermined by evidence as to permit little clear testing and choice among alternatives. And although there is some success at making theoretical terms more precise than underlying common sense notions, theoretical standards can rely on little or no pre-theoretical plausibility for their concepts which link them to practical concerns. As a consequence, practical applications of theoretical language are not substantially improved by being imbedded in a theoretical matrix. Nevertheless, we can

understand, I think, why the theoretical move is made. Its importance lies in the significance to us of the judgments we seek to make about our behavior. And this suggests that the motivation of the theoretical move is not so much a clarification of the account of behavior as an effort to justify the motives which underlie various characterizations of the behavior itself. These motives have been and are varied, and I will only sketch them here, suggesting that they are broadly moral and political in nature.

### The Normative Ascription of Disability

In modern times, as writers such as Michel Foucault (1973, p. 269f) have pointed out, classification of the mad was aimed at social reform. The apparently disabled or dysfunctional persons failed in exemplifying the manners and morals dictated by their communities. They failed to be productive workers and thus lacked fundamental values of being energetic and efficient members of the economy. Or they lacked those social graces, manners, and sense of decorum which qualified them for membership in bourgeois society. Indeed the introduction of the physician into the asylum (a place where the mentally disabled were sheltered from the pressures of the larger society until they could reform their wits) was as an examplar of moral and civic rectitude. It was not the physician's medical knowledge that was sought, but his or her moral probity.

A second motive is closely linked to our own sensibility today. We perceive much treatment of deviance, past and present, as cruel, inhumane, and perhaps ineffectual. To change our view of deviance from a category of misbehavior to one of disability and malfunctioning effects at the same time a change in our responses toward deviant behavior. We can now sympathize with such persons and oppose cruel treatment. By changing their role from malingerer to hysteric, from deceiver to genuinely ill or disabled, we effect a transformation in our own response. Szasz (1961, chapter I) has convincingly shown this to have been a primary factor in Charcot's reclassification of patients in the Salpêtrière, leading to the later work of Breuer, Freud, and others.

In addition to justifying more humane and benevolent treatment, theoretical reclassification has had a long and complicated history in the law where disablement functions both as an excusing factor in the commission of crimes and a justifying factor in the use of legally sanctioned force to control deviant behavior. I do not want to suggest that this legal tradition has not been based in part on moral feelings and a concern for the status in the law of rational agents. But it has largely derived from concern with the social control of deviance and the disagreeable effects of deviance on those persons, family, friends, neighbors, victims, "society" at large, who fit the social matrix more comfortably. Indeed, Moran (1981) has recently argued convincingly that the *locus classicus* of insanity trials, that of Daniel McNaughton, was a disguised political trial whose defendant was labelled insane rather than confront the political implications of

an assassination attempt whose motivations lay deep in the Chartist opposition to the Peel government.

If I am right, then the theoretical move is based significantly on ideological motivations, and needs always to be assessed in the context of such concerns and not viewed solely as an account indifferent to moral and political judgments. Perhaps I can make this more clear by reference to the standard ideological poles, conservative and liberal, as framing a spectrum of political sensibility. By and large, a conservative judgment on these issues opts for viewing people as essentially free and autonomous individuals whose personal authority and integrity lie in choosing to act in light of self-interest and uncoerced contractual agreements with other similar persons. Transgressions of such agreements or any gratuitous harm to or impairment of the freedom or autonomy of others is viewed as evil or bad and the individual is assumed to accept full responsibility for both such transgressions and for the achievements and failures of personal talent. The appropriate response to transgressions is punishment; the deserved result of personal achievement is reward. Liberal attitudes tend to modify the austerity of this individualistic account, stressing nurture over nature as the source of individual talent, and social and economic conditions as the measure of freedom and autonomy. People are seen as interdependent and limited by social or communal ties. Individual actions are thus conditioned by social constraints, expectations, opportunities, and pressures which render them less than fully autonomous. Responsibility is thus blurred and relative to the social and economic context which shapes individual personality. Transgression of social norms, then, reflects social conditioning as much as individual choice, which is itself understood only in a framework of limiting social possibilities. Response to deviance is thus couched not in terms of individual responsibility and punishment but in terms of treatment, re-education, and social reform. Achievement, though desirable, is not deserved, but manifests opportunities not yet universally available in an imperfect and changing social order.

Theoretical attributions of mental disability, then, will be determined in part by where one falls on this ideological spectrum. To the right, motivations will prompt an unsympathetic view of the phobic, paranoid, or compulsive person as volitionally disabled. To the left, one will be inclined to excuse and explain such behavior as manifestations of disabling mental conditions. By analogy, consider three different diagnostic principles, one from medicine, one from law, and one which might govern the ascription of disability in the cases we have been discussing. In medicine, the principle might be expressed: consider a person healthy until proven sick.[7] In law the principle is more familiar: consider a person innocent until proven guilty. In the context of mental ability: consider

[7]Szasz believes, for example, that rejection of this principle is both bad science and "practically very unwise." It is clear, furthermore, that he believes that it holds additional moral and political consequences which are unacceptable.

a person able until proven disabled. In each of these cases, the standards of proof and evidence differ and the procedures, if any, for adjudicating conflicts in judgment are also different. My point, however, is to stress the similarities and to claim that the stringency with which we apply these standards (even their acceptability and formulation) are dependent on our motivations and ideological orientation. Indeed, the latter may well be defined by the varying stringency with which we apply whatever standards of proof or evidence are available to us in each of these categories.

If these views are correct, then our conclusion must be as follows. Control (or treatment or excusing) of deviance is not justified because people are disabled; rather, disability is ascribed to people to justify the control we feel obliged to exert. We hold people responsible (and hence not disabled) for those actions we deem too important to dismiss and where behavior falls within generously construed bounds of species norms; we excuse (as disabled) those persons whose actions we are willing to set aside and whose patterns of behavior are radically deviant from species or social norms. Such judgments, then, effect an interaction among various interests as we seek to assess the plausibility on behavioral evidence of mental disability and to ascribe on the basis of moral, legal, political, and social concerns the responsibility and autonomy which accords with our conceptions of human agency.

Does this mean that no sense can be made of the notion of mental disability and hence of mental disease? No. Some sense, as I have suggested, can be made of it. But I see little prospect of its being based on genuinely theoretical grounds. Ascription of disability or ability is theoretical only in the limited sense that it goes beyond or is undetermined by behavioral evidence. Such theories of human behavior as we have go little beyond the scope of common sense insight at its best and consist mostly in systematizing those insights and making some of their conceptual expression in terms of wants, desires, motives, etc., somewhat more precise and coherent. But theory on analogy with those of physical science is not, I think, to be found. Indeed, so far as human behavior can be given a theoretical construal at all, it is in terms of the theories of biology and physics. But such theories, rather than clarifying the concepts of mental illness, disease, and disability, render them otiose.

But it *does* mean that not enough sense can be made of the notion of mental disability to carry the weight of practical action. And that is why mental illness is too important to be left to medicine or psychology where this stipulation is not often recognized. We must resolve such matters as substantially and broadly moral and political, as requiring decisions about the scope of individual freedom, community security, legal control, and tolerance of deviance from social norms.

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