

Replies to Commentaries*

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1 | REPLY TO SILVERS

My gratitude to Anita Silvers is tinged with sadness for her loss. She has gifted me with a charitable and fascinating extension of my account of disability, and I am heartbroken that I will never be able to discuss it further with her. I don't, in this reply, have the space to fully explore all the ideas that she raises, so I will focus on two key points.

The first is the connection between normativity and social ontology. In developing my account of disability as a social category (section 1), I've sought to carve out a path between realism and more traditional versions of social constructivism. The standard realist conception of disability views it as a purely biomedical phenomenon. Disabilities *just are* certain biological defects or dysfunctions which cause limitation in ability or fitness. What individual disabilities have in common with each other is their status as biological dysfunctions, limitations in fitness, etc.

On my account (section 1), disability is also a matter of one's body being in a particular state (many of which it makes sense to classify, in biomedical terms, as dysfunctions or defects). The problem with standard views of disability, as I see it, is not that they require that disability involves one's body being in some (objectively verifiable) state. The problem is simply that this is very far from the whole story. As Silvers emphasizes, the biological component of disability is important to understanding what disability is and how disabled people function in society. Disabled bodies are biologically atypical, and their atypicality involves limitations or significant differences in the functioning of the human organism. Moreover, this atypicality is causally related to the disadvantages that disabled people face.

I've tried to develop an account of disability which allows for all of this, and yet leaves open the question of whether disability is the kind of thing that, by itself, makes people worse off. By way of analogy, it is a biological reality that human reproduction places a greater burden on the female body than the male body. And this biological reality is causally related to many disadvantages that women encounter in the workplace. But this doesn't mean that these disadvantages aren't primarily social. Yes, there is a biological reality that is a cause of some disadvantages that women face. But the most straightforward solution to this disadvantage isn't to alter the biological reality. Rather, it's to address

*I'm grateful, for their advice and helpful discussion, to Liam Kofi Bright, Ross Cameron, Michaela McSweeney, Kevin Timpe, Jason Turner, Alana Wilde, and Robbie Williams. And of course I'm more grateful than I can say to Tom Dougherty, Eva Kittay, and the much-missed Anita Silvers for their challenging, fascinating discussions of my work. To have philosophers like these take the time to carefully and critically engage my arguments is the best gift I could receive.

the way in which our social system penalizes these types of differences via policies like paid maternity leave, accommodation for breast-feeding in the workplace, access to birth control and abortion, etc.

Importantly, it's not part of this view of justice for disabled people – which both Silvers and I endorse – that social policy can ameliorate *all* the limitations or difficulties that disabled people encounter because of what their bodies are like. Social policies can make things fairer and more just without getting rid of all difficulties. No amount of paid maternity leave can remove the exhaustion, physical trauma, and pain that female bodies endure in the process of pregnancy and breast feeding. But they *can* make things fairer, enhance women's chances for success, and help women to flourish. And they can do all of this without any assumptions about whether such policies are targeted at making up for ways in which those with female bodies are somehow, on the whole, *worse off*.¹ (That is, social policies like maternity leave and abortion access don't need to be framed as good-natured efforts to make up for the ways in which women are unlucky or unfortunate in virtue of having a uterus.) Wellbeing is complicated, and it's consistent with the claim that women aren't, overall, worse off than men that women often face unique disadvantages, some of which are natural consequences of the types of bodies many women (as well as some people who aren't women) have.

Obviously the analogy here is incomplete – the limitations and difficulties involved in having a disability are typically more long-term and in many cases more pervasive than those encountered in pregnancy, and they are typically unchosen (although so are, it should be emphasized, many pregnancies). The point is simply that all the following are compatible: (i) disability involves limitations and difficulties that are biological in origin; (ii) much of what we need to change to make the world more just for disabled people is social, not biological; (iii) even in a more just society disabled people would still face unique limitations and difficulties which are biological in origin; (iv) disabled people can and do live lives that are just as good as those who don't face these kinds of limitations and difficulties.

But this leads directly to a question I don't address in any way in my book. As Silvers states it:

[H]ow should the categories of flawed health and compromised functionality intersect and modulate each other[?] This question then is not just about what we now mean by concepts like illness and disability but also about the most propitious approach to conceptualizing how to treat individuals who manifest both these states

In discussing disability, I said almost nothing about health. But a full understanding of both the nature of disability and its impact on wellbeing requires that we grapple with the nature of health. Disability is much more than compromised health, and many disabled people are, overall, very healthy. But disability is intimately related to health in a way that other social categories – even those strongly correlated with health, such as race and socioeconomic status – are not. Many disabilities have direct negative consequences for health or are at least partly constituted by health problems.

And while I think it makes sense to defend In a mere-difference view of disability, a similar view about health disparities would be a disaster. One of the biggest negative effects of economic inequality is poor health outcomes. One of the biggest threats of environmental pollution is negative effects on health. One of the biggest parts of the disability rights platform is better access to health care. And so on. Whatever health is, it seems wrong to say that poor health is *just as good* as vibrant health. Health and wellbeing aren't directly correlated, and it's possible to have high levels of wellbeing while in poor health. But health *matters* to wellbeing in a way that a mere-difference view of health disparities would obscure.

I discussed these complexities with Anita the last time I saw her, and she told me – in a way that was something between a descriptive statement and a command – 'your next book is on health, of

¹Silvers has eloquently argued against the 'compensatory' model of accommodation, on which accommodations are owed to disabled people as a way of compensating for their natural bad luck. See, e.g., Silvers (1995).

course. That's the obvious big question to tackle next'. Anita, as usual, was right. I'm going to try, in future work, to tackle the questions of what health is and how health and disability are related. But the project will be poorer for not having Anita's insight to help guide it.

2 | REPLY TO DOUGHERTY

My interest in developing a modest form of realism about the category disability – what I think of as a realist interpretation of social constructivism (section 1) – brings me to the issues raised by Tom Dougherty in his generous and thoughtful commentary. Dougherty focuses on what I mean by my claim that disability, as a social category, is of philosophical interest primarily because of the way in which it has been used to organize people into a civil rights movement. As Dougherty outlines, this brings up an interesting question of what the relationship between theorists and activists should be, and how activism can inform or guide philosophical interpretations of social categories.

I agree with much of what Dougherty says, but ultimately my view departs a little from the one he develops. When I say that disability, as a social category, should be of interest to philosophers primarily because of the way it has been used in the disability rights movement, Dougherty is right that I mean it should be of interest because of the way in which it helps us understand and explain injustice. But my interpretation of what this means is tinged with more realism about social categories than Dougherty's.²

I think a major challenge to any attempt to give a social ontology of disability is error theory – the worry that there is no thing that can play all the roles we want a category of disability to play, or nothing that in fact unifies all the different physical conditions we label 'disabilities' apart from the fact that we use that word to refer to them. But I think that the role a social category like disability plays in organizing people in a civil rights movement and allowing people to talk about shared aspects of their experience is *evidence* that error theory is not the way to go. It is, of course, defeasible evidence, but it's at least some sign that there's something there that is unifying, and something that needs to be explained.

Furthermore, Dougherty is right – and articulates much more clearly than I did – that I ultimately think that disability is interesting and important as a category in social ontology because it allows us to *explain* a certain type of injustice. That is, I think that a view which says that there's really no such thing as disability doesn't have the resources to fully explain the systematic ways in which people we think of as disabled are discriminated against, or to fully explain the ways in which people we think of as disabled have a shared set of social experiences and a shared set of issues they are advocating for in order to better their own social situation.

Dougherty and I disagree somewhat, however, on what stance a position like this should lead us to regarding the relationship between theoretical and pragmatic considerations. This is largely a question of how best to interpret the idea of what Sally Haslanger terms an 'ameliorative project'³ – a project in philosophy that takes into consideration our 'legitimate political and social goals.' I'm a bit unclear, in my book, about how strongly I want to interpret the idea of an ameliorative project, mostly because I was rather unclear about it in my head. But I've thought about it at length since, and the interpretation I've landed on is slightly different than Dougherty's.

Quite simply, I think that we should endorse a less stigmatized ideology of disability because I think this ideology is *true*. I don't think that the pragmatic benefits of an ideological claim are sufficient for

²I discuss some of these issues in more length in Barnes, E (2017) and Barnes (2019). Dougherty actually wrote his discussion of my book before I wrote either of those papers, and thinking about his reply is a big piece of what prompted me to write them the way I did.

³See especially Haslanger, Sally (2000).

endorsing it, and I don't think that, at least when doing philosophy, I should determine ideological commitments based on what will best help achieve specific political or social goals. This is because I think that sometimes beliefs or ideological commitments that are false can nevertheless be extremely politically effective. The social utility of a claim might matter a lot when deciding how to frame rhetoric, but I don't think it should be a factor when deciding whether to believe it – at least while doing philosophy. It would probably make the lives of disabled people a lot better if more people believed and endorsed the idea that disability somehow makes people especially intuitive, wise, or kind. But, sadly, this is false -- as much as I would like it to be true. Likewise, I think there's no denying that the Social Model of disability – and most especially the claim that the disadvantages of disability are entirely caused by social prejudice rather than biological dysfunction – has been incredibly politically effective. And for that reason, I'm grateful for its popularity and influence. But when I'm evaluating claims as a philosopher, I care mostly about whether they're true – and I think there's good reason to think the Social Model isn't true.

The Social Model also illustrates another important problem for the idea that political effectiveness should be a guide to belief: political effectiveness is rarely an all or nothing matter. Although the Social Model has been incredibly politically effective, it's also proved alienating for some disabled people whose experience of disability is medically complicated, progressive, or painful. Similarly, the medicalization of disability was, historically, a major part of de-stigmatizing disability as a sign of sin or moral weakness, and was politically very effective in establishing various protections for disabled people. Social progress is often incremental, and sometimes an idea is an important part of getting us a few steps along the way, even if that idea simultaneously promotes some harms. And importantly, the progress that such ideas help us make doesn't change the fact that they can be false.

But Dougherty is of course right that this leaves something puzzling about what I said about ameliorative projects and social progress in the book. In a nutshell, my view is something like an optimistic bet. I think that better understanding the social world will help us make social progress. Haslanger talks a lot about 'debunking projects'⁴ – projects in philosophy which seek to explain why commonplace beliefs are wrong in some systematic way, and that the social kinds we're talking about aren't quite what most people take them to be. I think it's plausible that debunking projects are a part of social change. For example, it seems plausible to me that successfully promoting justice and inclusion for disabled people requires an understanding that disability is more than just biological dysfunction. But I think this is plausible at least in part because disability *really is* more than just biological dysfunction, and so you miss part of what needs to be advocated for if you treat it like it's just biological dysfunction (that is, if you don't fully understand what disability is.) But this is, at best, a hopeful hypothesis about the connection between truth and justice – one for which I have limited evidence. Perhaps I am wildly naive in thinking this, but I genuinely believe that understanding promotes justice, and that many injustices are rooted in pernicious falsehoods. By seeking to understand what disability is – what is *true* about disability – I think we can give good reasons for why many of the harms inflicted on disabled people are rooted in falsehoods. When doing philosophy, I want to know the truth. I *hope* that the truth will set us free. But that, I suppose, remains to be seen.

3 | REPLY TO KITTAY

Eva Kittay, in her incisive and thought-provoking commentary, challenges my decision to focus on physical disability. She also suggests that this decision is unnecessary, because much of what I say about physical disability could easily be extended to other forms of disability. I want to

⁴See especially Haslanger, S. (2003).

acknowledge, before proceeding to discuss this issue, that there is a long and unfortunate history, in discussions of disability, of prioritizing the experiences of physically disabled people. And insofar as my book is an instance of this, it's at risk both of unfairly ignoring other types of disability and of further marginalizing people with cognitive or psychological disabilities by prioritizing physical disability.

However, these potential pitfalls fully acknowledged, I do think there is a benefit to giving separate philosophical attention to physical, psychological, and cognitive disabilities, respectively. A theory of disability which gives a unified analysis of all three has the advantage of showing the way in which stigma against these groups shares striking similarities, and avoids marginalizing cognitive or psychological disability by (whether inadvertently or not) prioritizing physical disability as the 'paradigm case' of disability. But philosophical theories can be *too* unified. What they give us in elegance can, in places, obscure differences and complexities that are important.

Kittay rightly emphasizes that all forms of disability share a type of stigma. Disabled people – regardless of the form of disability – are viewed as defective, as especially needy or burdensome, as tragic, and so on. And Kittay is right to emphasize that such stigma can create a commonality of experience. But despite that common core of stigma – which creates many shared social experiences and social goals – there are significant differences that it is important not to overlook. In what follows, I'm going to briefly discuss some of the most central of those differences. In doing so, I hope to give a partial explanation of why I think a philosophical analysis that focuses specifically on physical disability is warranted, and why I think the account of physical disability I present in *The Minority Body* is not easily extendable to all forms of disability.

To begin with, it's important to recognize that, while all the things we currently classify as 'disabilities' share, as Kittay rightly observes, core aspects of stigma, it doesn't follow that we're correct in labelling them all 'disability'. This is a tricky point to make, since of course stigma is never correct in the first place. But a striking aspect of disability history is the way in which the language and ideology of disability has been used to perpetuate the unequal treatment of other groups – including immigrants, racial minorities, and women.⁵ Often, we describe features we don't like or find foreign – same-sex attraction, being a woman who misbehaves, etc – as disability in order to justify or perpetuate our dislike of them. In cases such as these, it is simply incorrect to say that the persons in question are disabled, even if they face many of the same kinds of stigma that disabled people do, and even if the language of disability is used to describe them.

So, for example, if we say that a person is disabled because they use a wheelchair, we're describing their social position correctly, but implying false things if we suggest that this makes them less valuable. In contrast, if we say that someone is disabled because they are gay, we're both implying false things about their value *and* describing their social position incorrectly.

This is especially important to emphasize in the context of psychological disabilities, because they, substantially more so than physical disabilities, are currently contested categories. We can see this vividly when we look at the controversies over diagnostic categories in the DSM.⁶ In some cases, the problem is that we mistakenly categorize something as a mental disorder. The most famous example is, of course, the inclusion of homosexuality as a type of mental disorder. Same-sex attraction is a real

⁵See especially Baynton, D. C. (2013).

⁶The DSM is, to put it mildly, controversial within discussions of psychological disability. In referring to it, I don't intend to suggest that it is authoritative or the final word on psychological disability. But insofar as the DSM is widely used, it is influential in what kinds of things are *viewed as* psychological disabilities, and that's what matters for the point I'm making here.

phenomenon, but it was never a psychological disorder. A more current example is, plausibly, DSM V's inclusion of gender dysphoria. People definitely experience the phenomena described as gender dysphoria; what's contested is whether the people who experience gender dysphoria have a mental disorder in virtue of this.

In other cases, the problem is that it's unclear whether the thing that's being described as a mental disorder exists at all. Prime examples include Premenstrual Dysphoric Disorder or Female Orgasmic Disorder. These are diagnostic labels for mental disorders. But whether these diagnostic categories represent genuine mental disorders rather than a pathologization of the female mind and body remains a topic of intense debate.⁷

The contested nature of psychological disability is further complicated by the fact that inclusion criteria for specific psychological disabilities is almost always a cluster of symptoms, and those symptoms are almost always subjectively reported or observed. There is no blood test, MRI, or ultrasound that can confirm a diagnosis of depression, for example. It is perhaps unsurprising, then, that already vulnerable populations – especially women and children – are especially prone to the overdiagnosis of mental disorder and disability.⁸

The basic point that I am making is this: it's important to differentiate between *being stigmatized as disabled* and *really being disabled*. And this is especially important in the context of psychological disability, where the issues of what mental phenomena should be included in the discussion is incredibly complicated and fraught. The simple fact that someone faces discrimination because they are perceived as disabled doesn't, by itself, settle the question of whether they really are disabled. And it definitely doesn't settle the question of whether they have something substantial (apart from social labelling) in common with, say, someone who uses a wheelchair or someone who has MS.

I am therefore skeptical that merely sharing a common type of stigma is enough to explain how physical, psychological, and cognitive disabilities might form a unified kind. And so I think it's worth thinking critically about whether the various forms of disability really do form a unified kind. And with that in mind, I want to consider a few key differences between the various forms of disability that might affect whether and to what extent a single analysis (and more specifically, my analysis) can work for all of them.

As Nomy Arpaly carefully argues⁹, psychological disabilities are connected to *meaning* in a way that physical disabilities are not. If you have MS, we can say that your immune system is behaving abnormally. We can say that you have atypical autoimmune activity. We can say that this autoimmune activity is causing nerve damage. And so on. But we can't say that your immune system's activity is *unwarranted*. In contrast, our understanding of many psychological disabilities often requires precisely this kind of claim. You aren't psychologically disabled merely in virtue of being in a particular psychological state. Rather, at least in many cases, that state has to bear some particular kind of relation to meaning, justification, reasons, etc. A person who is constantly fearful, nervous, in a heightened state of apprehension, etc doesn't automatically have an anxiety disorder. Whether she has an anxiety disorder depends on what she's responding to. If you're feeling constantly anxious because you're in a war zone, that's just what it's like to be a war zone. But if you're feeling constantly anxious in suburbia for reasons you can't quite articulate, that's what it's like to have generalized anxiety.

⁷It's worth noting that some accounts of psychological disability don't see a distinction between ways we pathologize difference and mental disorder – categories of mental disorder are, on these views, nothing more than ways to label certain people as deviant. See especially Rashed, Mohammed (2019).

⁸See, for example: Eric R. Coon et al (2014).

⁹Arpaly, N. (2005).

Likewise, we can't understand depression simply by talking about an individual's state of mind. As Horowitz and Wakefield persuasively argue in *The Loss of Sadness*,¹⁰ part of our basic understanding of depression is not just how it feels, but also *why* those feelings arise. If you are crying constantly, have lost interest in your hobbies, feel bleak and cynical, all because a beloved family member has just died at a young age, that's not depression – that's grief. In contrast, you might feel all those same things and not know why, or feel all those same things in a way that seems to you like an exaggerated response to something relatively minor or something that happened a long time ago – that's depression.

A closely related point of difference between psychological and physical disabilities is their connection to rationality. Psychological disabilities often – not always, but often – have a more intimate connection to rationality than physical disabilities do. This is especially relevant to debates about the relationship between disability and wellbeing – such as those I engaged in my book – because it complicates the evaluation of first-person testimony. In general, an important part of getting information about wellbeing and quality of life is asking people about their own *perceived* wellbeing and quality of life. And it's this type of first-person testimony about wellbeing that's at the core of many of the arguments I give in my book. Of course, for any case of individual testimony about wellbeing in the context of physical disability, we might have reasons to be skeptical – we might worry about adaptive preference, status quo bias, recall bias, hedonic shift, etc. But these are *general* worries about how we evaluate first-person testimony about wellbeing; they are not specific to physical disability itself. Physical disability might make certain well-known problems about first-person reports of wellbeing – such as adaptive preference or status quo bias – especially salient. But it doesn't create any problems about relying on testimony that are specific to the experience of disability.

With psychological disability, however, things become more complicated. And they become more complicated precisely because of the way in which many psychological disabilities are intimately connected to understanding, interpretation, and rationality. Suppose that someone with depression tells me that, in general, their quality of life is very poor. Do I take this report at face value? Or should part of my evaluation include the fact that, for many people, a constitutive feature of depression is a tendency to devalue positive experiences? (To take the most extreme case, people with depression sometimes feel that their lives are so bad as to not be worth living, and we obviously do not take them at their word about this, but rather consider it a tragic manifestation of their depression that should be addressed with care and treatment.) On the flip side, it's not uncommon for people with eating disorders such as anorexia to deny that there is anything pathological or harmful about their behavior, and to insist that their behavior is healthy and promotes good quality of life. Again, we don't – and shouldn't – take these reports at face value, precisely because of the ways in which an eating disorder can distort thought patterns.

What seems reasonably clear is that sometimes first-person reports about wellbeing in the context of psychological disability can themselves be *manifestations* of the psychological disability. (In a way that, for example, testimony about having a spinal cord injury is never a manifestation of the spinal cord injury itself.) And in cases such as those, distinctive epistemic issues arise for how to understand and interpret the testimony in question.

Finally, some psychological disabilities have a distinctive connection to morality in a way that physical disabilities do not. (Here I'm again drawing heavily on the work of Nomy Arpaly). For some things that we consider psychological disabilities, there seems to be a constitutive connection between having that condition and doing things that are typically considered wrong or inappropriate. Part of

¹⁰Horowitz, A. V., & Wakefield, J. C. (2007).

what it is, for example, to have narcissistic personality disorder is to have an aggrandized self-image and a lack of concern for others. Part of *what it is* to have psychopathy is to lack empathy and emotional engagement with others.

How, exactly, to understand this connection to morality is an incredibly difficult question. So is the resulting question of how to think about blameworthiness in these contexts. I'm not attempting to address any of these complex questions here. Rather, I'm simply arguing that these are difficult questions that *need* to be addressed in any viable theory of psychological disability, and it's one key point where psychological and physical disabilities diverge.

It's precisely due to differences such as these that I think my account of physical disability can't be *easily* extended to psychological disability. In my work, I argue (in Sections 2 and 4) for what is sometimes called an *affirmational* approach to physical disability. Although physical disability can and does involve harms, it is not, on my view, something which by itself or intrinsically makes a person worse off overall. And in light of this, the unique experiences that physical disability gives rise to are something it makes sense to celebrate and even take pride in. Whether it makes sense to extend this view to psychological disability, however, is a fraught question.

Something like an affirmational approach might well be appropriate for some psychological disabilities, but it is clearly not appropriate for all of them. All forms of disability face stigma, and that stigma needs to be combatted. But an affirmational approach seems like the wrong way to combat stigma for at least *some* psychological disabilities. Given the way in which psychological disabilities can sometimes connect to meaning, rationality, and morality, an affirmational view of such disabilities – rather than being a way of combatting stigma – is itself a way in which these conditions can harm and distort thinking patterns. Again, this needn't be the case for all psychological disabilities; but it seems to be the case for at least some of them. And consequently, an affirmation approach to disability – including arguments for Disability Pride – can't simply be extended to psychological disability without at least grappling with this complexity.

Consider, once again, eating disorders like anorexia. There are online 'pro-anorexia' communities in which people adamantly express the view that eating disorders are positive traits that should be celebrated. But in this case, the positive view of anorexia appears to be part of the pathology of the eating disorder itself. Similarly, people who experience paranoid delusions as a result of schizophrenia are often very reluctant to accept treatment, in part because they believe that such delusions are valuable, giving them insight into the real truth that others (doctors, friends, etc) are trying to obscure. And again, this belief is part of the condition itself – it's part of the way in which paranoia manifests.

The range and complexity of psychological disabilities also makes it unclear whether the kind of solidarity-based approach that I endorse (Section 1) in giving a definition of physical disability can be extended to psychological disability. Certainly, there are types of psychological disability which the efforts of the disability rights movement – such as arguing for better accommodation and accessibility practices, better access to healthcare, and so on – will directly benefit. But it doesn't seem, at least to me, that this will be the case for all the things we currently think of as psychological disabilities. And this is because of the strong connection to morality had by some forms of psychological disability. We don't accommodate psychopathy, pyromania, or narcissistic personality disorder in the way that we accommodate depression, and nor does it seem like we should. We of course need to attempt to understand what's happening when a person has pyromania, and we need to be able to offer treatment – but that's not the same thing as offering *accommodation* for pyromania. A straightforward extension of a solidarity-based approach seems inadequate to account for the complexity of mental illness.

Perhaps what is needed are further distinctions within the broad category of what we currently think of as psychological disability. Maybe there's an important difference between *psychological*

disability and *mental illness*. Or maybe we need to distinguish morally-laden forms of mental disorder (psychopathy, pyromania) from other types of mental disorder (anxiety, depression, etc.) I'm not sure how these distinctions would be drawn or what the right thing to say about these various cases is. But the complex questions raised here make me skeptical that my account of physical disability can straightforwardly be extended to psychological disability.

One final – and important – consideration against extending my account of physical disability to psychological disability is simply the intricate relationship between some forms of psychological disability and wellbeing. Undoubtedly people with a wide range of psychological disabilities live rich, wonderful lives. Yet, on at least some theories of wellbeing, there is a connection between some psychological disabilities and reduction in wellbeing that veers close to analytic. I argue (Section 2) for the view that physical disabilities are *neutral* with respect to wellbeing – they do not automatically make your life better or worse (though on my view this is compatible with their making life go better or worse overall *for some people*, and with them always involving some types of harm.) I further argue that this view of physical disability is compatible with most mainstream contemporary views of wellbeing. I'm not sure that the same thing can be said for some psychological disabilities, however.

Interestingly, it's hardest to articulate a mere-difference view of some psychological disabilities for subjective theories of wellbeing, which are arguably the easiest views of wellbeing on which to defend a mere-difference view of physical disability. For subjectivist views of wellbeing, the connection between physical disability and wellbeing is indirect – a physical disability has to cause unhappiness, frustration of desires, etc in order to diminish wellbeing. And so the defender of the mere-difference view can argue, based on the reported experiences of many physically disabled people, that in fact this connection isn't as robust or reliable as most people assume. Some people are made unhappy by physical disability, but many others report that they are not; and many people made unhappy by disability are arguably made unhappy because of social factors – lack of access, stigma, etc – rather than any deep connection between disability and wellbeing. To argue for a mere-difference view, you simply dispute that there is a close or counterfactually reliable connection between the presence of disability and a reduction in subjective wellbeing. But for some types of psychological disability, the connection between the disability and a reduction in wellbeing looks – at least for many versions of subjectivism about wellbeing – constitutive of *what it is* to have the disability in question. Part of what it is to experience depression, for at least some people, is to experience unhappiness, anhedonia, or feelings of intense frustration (including feeling that things don't go your way, that you're perpetually dissatisfied, etc). And so if you think that wellbeing *just is* your overall level of happiness or desire-satisfaction, then the connection between depression and reduction in wellbeing, in at least some forms of depression, is constitutive: part of *what it is* to experience depression is to experience less of the things that make up wellbeing.

Unsurprisingly, this connection is directly born out in empirical studies of people's perceptions about their own wellbeing or life-satisfaction. As I discuss in my book, there are limits to what such studies can actually tell us about wellbeing, but they're interesting at least insofar as they tell us that physically disabled people are often very satisfied with their lives and don't rate their own happiness lower than non-disabled people generally do. In contrast, people with depression generally *do* rate their own life-satisfaction and happiness as substantially lower than people without depression.¹¹ And again, this is what you'd expect given that feelings of unhappiness and frustration are part of what depression *is*.

There might, of course, be ways to articulate a mere-difference view of depression even given this complexity. Or these considerations might be reason to endorse an objectivist view of wellbeing. I'm

¹¹See, e.g., Koivumaa-Honkanen et al. (2004); Nes et al (2013).

not sure what to say about any of this. But what I do feel confident in saying is that considerations such as these give us good reason to not simply extend a mere-difference view to psychological disability without at least grappling with this type of complexity.

I turn now to the relationship between physical and cognitive disability. Here again, the wide range of cognitive disabilities makes it difficult to give any sort of general take about this relationship. And, of course, many people with cognitive disabilities also have physical disabilities, and in many ways the line between the two is unclear. Certainly, movements like Autism Acceptance seem to have a great deal in common with calls for acceptance of physical disabilities. Likewise, people with Downs Syndrome are often active participants in Disability Pride parades and rallies. For cases like these, I think much of what I say in my book can be straightforwardly extended without much complication. For other cases of cognitive disability, though, I think that more needs to be said. And in general, there are important differences between cognitive and physical disability which it's important not to overlook simply because they share the label 'disability'. There are philosophical challenges related to cognitive disability which my book doesn't engage, and which, moreover, I felt I *couldn't* engage without biting off more than I could chew.

Many of the arguments I give in Section 2 for a mere-difference view of physical disability rely on the first-person testimony of disabled people. Such arguments don't easily extend to all forms of cognitive disability, though, because in at least *some* cases of cognitive disability this kind of testimony is unavailable. Some cognitively disabled people are unable to communicate verbally, others have some access to verbal communication but are unable to process complicated questions about their wellbeing or their feelings about disability. Kittay is correct, of course, that we make a mistake if we prioritize discussion of physically disabled people simply because physically disabled people are more able to speak about their own experiences. But we also make a mistake if we simply take what physically disabled people say and extend it to cognitively disabled people. Doing this centers and prioritizes the experiences of physically disabled people as well, and it unjustly assumes that physical disability can serve as a kind of 'paradigm case' for talking about disability, when it isn't at all clear – given the vast differences in different disabilities – that this is true.

What ought we to do, then? Kittay is right that parents and caregivers of cognitively disabled people have important things to tell us about the wellbeing of their cognitively disabled loved ones.¹² And cognitively disabled people who can't directly give verbal testimony can still communicate things to us – they can communicate their joy, their love, their happiness, their zest for life, even when they can't verbally articulate these things. But its value notwithstanding, such testimony involves different, and somewhat more complex, epistemic issues than straightforward verbal testimony about a person's own experience. In the case of caregiver testimony especially, it involves speaking for and on behalf of others. And while Kittay has rightly urged the importance of such testimony, any case of *speaking for* involves both moral and epistemic risks not encountered in basic first-person testimony.¹³

Similar considerations apply for extending the kind of solidarity-based account of physical disability I endorse in Section 1 to all forms of cognitive disability. I've argued that what unifies physical disability, as a kind, are the collective actions of the disability rights movement. But it is unclear whether the same story can be given for cognitive disability *in general*, simply because of the effect that cognitive disability can sometimes have on agency. Certainly, the kinds of things that the disability rights movement argues for – accessibility, accommodation, health care, etc – benefit cognitively

¹²See especially Kittay, Eva (2019).

¹³See, e.g., Alcott, L. (1991).

disabled people and are part of how we seek justice for cognitively disabled people. But for some forms of cognitive disability, this is *advocacy for* rather than *advocacy by* disabled people.

The disability rights movement has championed the slogan ‘Nothing About Us Without Us’ – which has typically been taken to mean that advocacy for disabled people, laws concerning disabled people, discussion of the lives of disabled people, etc should not be conducted without the input and involvement of disabled people themselves. But some cognitively disabled people cannot participate in advocacy, cannot discuss what legal protections would assist them, and so on – and they cannot do so precisely because of the cognitive impacts of their disabilities. Advocacy on behalf of such people is crucial to promoting justice for disabled people. But it is importantly different – it requires different types of effort and involves different moral and epistemic risks – than cases in which people advocate and organize on their own behalf.¹⁴

Cognitively disabled people face many of the same stigmas and are helped by many of the same protections and accommodations as physically disabled people. And many cognitively disabled people are also physically disabled. But the relationship between cognitive disability and physical disability, especially when we’re attempting to give a philosophical theory of one or both, remains complex. I’ve pointed to two key places where the philosophical analysis and arguments I present for physical disability are not straightforwardly extendable to (all forms of) cognitive disability. I suspect that much more needs to be said here, and I am grateful for the presence of so much emerging work on this issue.¹⁵

There is a long and unhappy history, within efforts for disability rights, of excluding and ignoring cognitively disabled people. Philosophical discussion of disability that focuses exclusively on physical disability risks perpetuating this exclusion. Likewise, Kevin Timpe has – rightly – raised the concern that arguments which prioritize first-person testimony risk further marginalizing those for whom such testimony is unavailable. On the other hand, we have too often lumped cognitively disabled people under the broad heading ‘disability’ in a way that obscures their uniqueness – both the unique challenges they face and the unique ways in which their experience of the world is valuable and rich.

I remain unsure what to think about the complex issues I’m raising here. I also remain skeptical that disabilities are easily sortable into a tripartite distinction of cognitive, psychological, and physical, or that this tripartite distinction is the right way to think about the varieties of conditions we currently label ‘disabilities’. What I’m fairly confident of, however, is that some of the main arguments I give regarding physical disability are at least not *straightforwardly* extendable to all the conditions we classify as psychological or cognitive disabilities. More needs to be said here, and these were complexities I simply felt unable to successfully tackle in my book. But my sincere hope is that my book can be one piece in an ongoing conversation about the multiple and varied ways in which people can experience disability.

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¹⁴To be clear, I’m not saying this is the case for all cognitive disabilities – advocacy for conditions such as Autism and Downs Syndrome is regularly undertaken by people with those conditions, for example.

¹⁵In addition to Eva Kittay’s seminal work, Kevin Timpe, Joel Michael Reynolds, Licia Carlson, Linda Barclay, and David Shoemaker – to name just a few – are all doing exciting work on this topic.

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