

In Defense of Madness: The Problem of Disability

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At a time when different groups in society are achieving notable gains in respect and rights, activists in mental health and proponents of mad positive approaches, such as Mad Pride, are coming up against considerable challenges. A particular issue is the commonly held view that madness is inherently disabling and cannot form the grounds for identity or culture. This paper responds to the challenge by developing two bulwarks against the tendency to assume too readily the view that madness is inherently disabling: the first arises from the normative nature of disability judgments, and the second arises from the implications of political activism in terms of being a social subject. In the process of arguing for these two bulwarks, the paper explores the basic structure of the social model of disability in the context of debates on naturalism and normativism, the applicability of the social model to madness, and the difference between physical and mental disabilities in terms of the unintelligibility often attributed to the latter.

Keywords: *intelligibility, Mad Pride, naturalism, normativism, philosophy of psychiatry, political activism, social model of disability*

I. INTRODUCTION

For a number of decades, there have been considerable attempts to develop positive narratives of mental health phenomena, narratives that can counteract the pervasive, negative views in society and the profession of psychiatry.¹ The context in which these attempts were and are made is a burgeoning movement(s) of activism and advocacy in mental health. A recent chapter

in this activism is Mad Pride, a movement and discourse that pose a direct and radical challenge to the social norms and values underpinning views on “mental illness.”² Mad Pride discourse rejects the language of “illness” and “disorder,” reclaims the term “mad,” and replaces its negative connotations with more positive understandings. It reverses the customary understanding of madness as illness in favor of the view that madness can be grounds for identity and culture. In addition, Mad positive approaches and framings abound in the writings of activists: phenomena of madness such as states of heightened sensory awareness, visions and voices, and the ability to perceive complexity and significance in everyday experiences are considered special and valuable, and not indicators of psychopathology. Their value is sometimes taken to arise from the creative, artistic, cultural, and spiritual potential afforded by these experiences.

Mad Pride discourse recognizes that madness can also be associated with distress and difficulties in social functioning. This Janus-faced nature of madness—at once a source of creativity and suffering—led to the formulation that individual traits and sensitivities are “dangerous gifts” that require cultivation and care.³ Yet, it is the question of distress and disability that has proved to be a sticking point for Mad Pride discourse and for mad positive approaches in general: how can one advance a positive framing of that which appears to be inherently negative? This criticism has been expressed strongly by service users as well as academics. Clare Allan, an ex-patient who has written about her experiences with mental health services, argues that there is nothing about “mental illness” of which to be proud. Although she recognizes the stigma faced by mental health patients, she understands Mad Pride as essentially a tactic to bolster the self-esteem of service users who, for years, have been subjected to stigma and disrespect in society and degrading treatment by services; she writes:

Mental illness is not an identity. Nor is it something I wish to celebrate . . . Mental illness is ruthless, indiscriminate and destructive. It is also an illness. It is certainly not a weakness, but nor is it a sign of a special “artistic” sensitivity. It affected Van Gogh, as it does bus drivers, plumbers, teachers, older people and children. Winston Churchill was reportedly manic-depressive, if so, it’s a diagnosis he shares with my friend Cathy, a mother of two from Peckham. Mental illness is an illness, just as cancer is an illness; and people die from both. (Allan, 2006)

A similar criticism can be found in the academic literature. Jost (2009, 2) writes that “mental illnesses” are not “*different* ways of processing information or emotion; they are *disorders* in the capacities for processing information or emotion.” It is absurd, she argues, to urge people to embrace such conditions and regard them positively. In making this point, Jost (2009, 2) draws a distinction between conditions that are disabling because the physical and social environment fails to accommodate variations in traits and characteristics, and “mental illnesses” that are “inherently negative” and “will

always cause suffering” even if stigma and disadvantage were to be eliminated. Perring (2009) writes that for some of those who object to the movement, the analogy with Black Pride or Gay Pride—an analogy made in Mad Pride discourse—can only go so far as none of these are intrinsically disabling features of a person while mental illnesses” tend to be seen as such. That is why, he notes, it would be equally bizarre to have a Cancer Pride movement. Such views, no doubt, have wide currency among many clinicians who see every day in the clinic the effects of “mental illness”: social and functional deterioration, loss of friends and family, and the distress of extreme mental states.

There is, therefore, a challenge facing Mad Pride discourse and mad positive approaches: the problem of distress and disability. In this paper, I respond to the problem of disability by developing two bulwarks against the tendency to adopt, too readily, the (medical) view that madness is inherently disabling: (1) the normative basis of disability judgments; (2) the implications of political activism in terms of being a social subject. To delineate the scope of my argument, I begin with two disclaimers: first, my concern in this paper is disability and not distress. The former, on an initial reading, consists in limitations to/impairments of everyday functioning and participation. The latter—distress—concerns affective states such as fear, anxiety, or sadness. The two can be connected, of course; intense fear can impact on functioning, and disability can engender anxiety. This connection will be noted as required, but the two concepts raise different issues and require separate consideration.⁴ Second, my purpose is not to argue *against* the medical model of disability but against the tendency to assume it too readily in the case of madness. I begin by clarifying the criticism of Mad Pride and mad positive approaches.

II. CLARIFYING THE CRITICISM

The problem of disability, as it emerges through the aforementioned criticisms of Mad Pride, can be more accurately stated as follows:

- “Mental illness” is associated with disability.
- This association is not contingent: disability is intrinsic to mental illness, which means that the various limitations experienced by individuals with those “conditions” are a result of the “conditions” and not an intolerant or unaccommodating society.
- By contrast, so the argument would go, the limitations experienced by gay individuals were/are a result of a homophobic society that denied them equal rights and the right to be themselves. Once we correct for social discrimination and oppression, the limitations that gay individuals face will reduce.

In brief, the criticism can be formulated as follows: even in a utopian world where there is absolutely no discrimination and a surplus of well-meaning regard that people show toward each other, “mental illness” will still reduce the well-being of those afflicted.⁵ To be clear from the outset, this statement cannot be intended as an empirical claim, not only because there are no studies of the fate of “mental illness” in utopia but because the proof demanded for this claim to work requires that the phenomena in question remain disabling for afflicted individuals once *all* socially discriminating and negative conditions have been removed. The problem here is that it will never be possible to assert that one has concluded the investigation, as it will not be possible to know if social conditions are the best they could be, assuming we can even agree on what “best” means. Given that it is not intended as an empirical claim, what exactly is the basis for it? To gain some further ground here, we can consider a possible response to this criticism, one that appears in the writings of some activists.

The response is to affirm that what is referred to as “mental illness” is a variation on human experiences and ways of being. The reason these variations may lead to problems in functioning has to do with a social world that is not set up to accommodate them and not due to a “disorder” or some intrinsic malfunction:

Most mental illnesses are seen as disorders because they prevent the person from functioning properly in the social world we have set up for ourselves . . . If the majority of the population was bipolar, things would be set up to accommodate them, and those without bipolar “symptoms” would struggle to fit in and understand the world. Is failure to hold up to the expectations of other people really a disorder? (Polvora, 2011, 4)

Both the criticism and the response to it purport to specify the locus of the problem: the former locates the cause of disability in the individual—in the “mental illness” to be precise—and the latter locates it in a society designed only to accommodate a particular norm. Essentially, then, the two positions here reflect a “medical” versus a “social” understanding of the limitations associated with madness. To arbitrate between them, I visit the social model of disability, a framework that has been substantially worked out in Disability Theory and can help make sense of this dispute.

III. MODELS OF DISABILITY

According to standard definitions, disability is comprised of a physical or mental *impairment* associated with long-term *limitations* on the ability to perform daily activities.⁶ For example, blindness, according to this framework, would be an impairment—or, for a less value-laden term, a variation in human functioning—that ordinarily would limit the person’s ability for

personal and social functioning and participation. The priority given either to impairment or to social context in generating limitations gave rise to a number of disability models, the most prominent of which are the medical and the social models. The medical (individual) model emphasizes variations as the primary cause of limitation and prescribes medical correction and/or financial compensation. The social model, endorsed in some form by many disability activists and theoreticians, emphasizes that limitations arise from a physical and social environment designed and conducted in such a way that excludes or does not take into account individuals with variations in traits or characteristics (Oliver, 1990, 1996).⁷ The social model shifts attention to restrictive and exclusionary conditions in society and prescribes various sorts of accommodations to address this. In the case of sensory impairments/variations, for example blindness, accommodations can include practical adjustments such as tactile and audio signage.

It is important at this point to introduce some complexity into the notion of limitation in view of the kinds of actions involved. Nordenfelt (1997) distinguishes basic actions from generated actions. A basic action, such as moving a limb, is a simple and primary action that constitutes the first step in the chain that ends with complex, or generated, action (Nordenfelt, 1997, 611). The latter are actions describable at the level of the person in terms of overarching goals such as “writing a book” or “making a chair.” To clarify the notion of basic action, it will help to see it not in predefined terms but as something that becomes apparent by its absence. In this way, we can avoid having to ground the notion in an account of species-typical natural functioning and can leave it open to individual variation. Further, the notion of basic “action” needs to be broadened to incorporate other aspects of our fundamental abilities that are not ordinarily thought of as actions. For example, a certain level of concentration is required to be able to focus on a task. Concentration, according to the account advanced here, is not a basic “action” but a basic “ability” that underpins much of what we do.

Ordinarily, we become aware of the basic nature of some of our abilities when we are thwarted in realizing our complex goals. Ideally, the body is the medium through which we project and realize our intentions in the world. It remains in the background as a transparent medium until, for some reason, its interference with our complex goals renders salient a particular aspect or function. It can be a painful limb, impaired concentration, poor vision, or a heightened state of anxiety. All of these can be considered within the scope of basic abilities in the sense that they are disruptions to the taken for granted background of our complex activity in the world and become salient when they hold us back.⁸ The point at which this occurs is as personal as it is cultural, and we need not for this view refer to an account of natural function.

On this basis, we can distinguish two levels of limitation. The first level consists in the basic inabilities (typified in disability models as impairments

or variations) that become salient when our complex activity in the world is disrupted.⁹ The second level consists in the disruptions to the complex activity itself: the inability to work, socialize, or go to the market. Now, though an impairment constitutes a limitation at the basic level—a blind person cannot see, a broken limb cannot bear weight—it is not by itself sufficient for limitations at the level of complex activity. Complex actions are always performed in some physical and social environment, and the extent to which we can realize our goals depends, in part, on the match between the environment and our (in)abilities (see [Amundson, 1992](#), 109–10).¹⁰ So, though a blind person may be unable to see (a limitation at the level of basic abilities), his inability to realize employment (a limitation at the level of complex action) can be addressed through specially designed working quarters that take into account his specific sensory abilities. Of course, one may wish to correct for the basic inability (the impairment)—to correct for loss of vision or hearing for example—but where that is not possible (technologically) or desired (e.g., Deaf Pride), then the variation/environment interaction can be scrutinized for impediments to the realization of specific complex goals.

Another helpful way to cash out the distinction between these two levels of limitation is in terms of the extent to which disadvantages are conditional on/produced by the social context. [Amundson and Tresky \(2007, 544\)](#) define the terms as follows:

Conditional Disadvantages of Impairment (CDIs): Disadvantages that are experienced by people with impairments, but which are produced by the social context in which those people live.

Unconditional Disadvantages of Impairment (UDIs): Disadvantages that are experienced by people with impairments, but which are produced irrespective of their social context.

Mapped onto the two levels of limitations specified earlier, basic inabilities would be unconditional whereas disruptions to complex activities would be conditional. Although I see a place for the distinction as such, I would not put it this strongly, as the notion of an absolutely unconditional disadvantage does not work. As I argued previously, a basic inability is made salient in the context of failing to achieve a complex action. The latter itself is relative to physical and social environmental contexts and hence is, in part, conditional upon them. So, it is more accurate to see this distinction as a matter of degree and not kind: as a distinction concerning the proximity of a particular description of disadvantage to one's physical and mental states as opposed to the environment in which one is pursuing goals.¹¹

The importance of the distinction between conditional and unconditional disadvantages is that it serves to limit the “oversocialisation” of the radical form of the social model of disability, which appears to deny a role for impairment in generating disadvantage ([Terzi, 2004](#), 153). With this distinction in

place, it becomes possible to argue, for example, that while a deaf person may be unable to hear and may not be able to listen to music, these particular “limitations” flow from the impairment/variation and are separate from the restrictions he or she may face in finding employment or watching the news when no alternative form of communication, such as sign language, is made available.¹² The former are basic inabilities—whether or not they are undesirable—and the latter are the limitations caused by an unaccommodating social environment. As Amundson and Tresky (2007, 544) note, in disability rights discourse unconditional disadvantages “are taken as brute facts of human variation” and are not considered within the scope of disability claims and campaigning. Similarly, the social model—writes Oliver (2004, 22), the person credited with its introduction—“is not about the personal experience of impairment but the collective experience of disablement.”

Having made this distinction, it is important to note that there is no hard and fast way of drawing the line between unconditional and conditional disadvantages. The distinction is worked out in practice, leaning heavily on disabled peoples’ experiences and on what exactly the demand for social accommodation is about in the context of wider debates on these issues (see Amundson and Tresky, 2007, 553). Yet, the problem with the medical model of disability, and with the criticisms of Mad Pride described earlier, is that this distinction—if it is made at all—appears to lean too heavily on one side, with all or most limitations considered to arise from the impairment/variation. Such medical models conflate the two levels of limitation discerned earlier or recognize them as distinct but put too much emphasis on basic inabilities over disruption to complex activity. The area of contention then lies precisely at the boundary where what is put forward by disability rights activists as a conditional disadvantage is seen by advocates of the medical model as an unconditional disadvantage flowing from, or intrinsic to, the impairment itself. It is the latter, medical view that I consider problematic and to which I now turn.

IV. NATURALISM, NORMATIVISM, AND DISABILITY

Critics of the medical model of disability have argued that the claim that limitations are “caused” by the impairment—that, say, not being able to access information is caused by a person’s sensory impairments—presupposes a naturalistic view of function (Amundson, 2000). Naturalism is the view that norms of physical and mental functioning can be objectively determined. Two well-known naturalist accounts have been put forth by Christopher Boorse and Jerome Wakefield. For Boorse (1997), a normal function of a part or process of an individual is a statistically typical contribution by it to the individual’s survival and reproduction. Statistically normal function is determined relative to the individual’s reference class, which is the appropriate

segment of the species as defined by age and sex.¹³ For Wakefield (1992, 384), the natural function of a mechanism is the function for which it has been designed (selected) in evolution; it is “part of the evolutionary explanation of the existence and structure of the mechanism.” For example, the heart pumps blood, the legs move our body, and the visual system conveys perceptual information about the world: these are natural functions of the respective organs; they are what the organs were designed to do.

On the basis of their accounts of natural function, Boorse and Wakefield can then purport to specify physical or mental dysfunction in value-free terms as deviation from natural function. Both also recognize that that is not sufficient by itself to delineate the conditions that should be treated. For Boorse (2011, 28) and Wakefield (1992), a further evaluative component is required, which consists in the evaluation of this dysfunction as harmful in light of personal, social, and medical norms and values. On Wakefield’s formulation, disorder becomes a *harmful dysfunction* or—which amounts to the same thing for our purposes here—a harmful *impairment*. With this kind of reasoning, a blind person would have a dysfunction/impairment in the visual apparatus that, if associated with harm, would qualify the condition as a disorder. And given that according to naturalistic accounts function is a matter of objectively determined natural facts—with dysfunction being a deviation from normal function—then the limitation, the harm, that may arise from this is referred back to the dysfunction and not to a deficiency in the design of the physical and social environments relative to the functional abilities of different persons. This is because the person with a dysfunction, on this view, lies outside the range of normal functional abilities, and he or she lies outside this range not due to some inconsiderate value judgment but by the facts of human nature.

The problem with naturalistic theories, and therefore with the foregoing argument, is that attempts to define dysfunction in value-free terms have not been successful. This debate has been well rehearsed by several philosophers and I will only state their conclusions.¹⁴

Since its inception, Boorse’s theory has been subject to a lively interchange and many objections. Of particular relevance here are accusations of implicit normativism in both the notion of statistically normal function and the reference class against which this is to be assessed. With regard to the former, Bolton (2008, 113) points out that statistical (ab)normality does not by itself tell us at what point on a continuous distribution curve “deviance from the mean become(s) subnormal function.” Factors that in fact do underlie this judgment are those associated with the value component: harm and functional limitations as judged by personal and, more broadly, social values and norms. As a principle purporting to provide a factual basis for discerning normal from subnormal function, statistical normality does not work. With regard to reference classes, Kingma (2007, 2013) argues that Boorse’s account requires that he specify the reference classes appropriate to

an assessment of health. Otherwise, any condition can be rendered healthy if we devise a reference class that shows it in a good light. For example, if we were to allow for a reference class of “uncommonly heavy drinkers,” then liver functions that would otherwise be considered abnormal would no longer be so, and those heavy drinkers, according to Boorse’s account, would be considered healthy (Kingma, 2007, 128). Boorse, therefore, needs to provide an account of the appropriate reference classes, and he needs to do so in a value-free, noncircular way, i.e., without introducing values into what is supposed to be a fact-based definition of normal function, and without presupposing the distinction he is trying to prove between health and disease (Kingma, 2007). As Kingma (2007, 2013) argues, Boorse’s account cannot provide this.

Wakefield’s *harmful dysfunction* analysis of disorder has also met with serious objections. Dysfunction, as noted earlier, is deviation from the natural function of a mechanism: the function that explains, in evolutionary terms, the mechanism’s existence and design. For our purposes here, the most relevant objection to Wakefield’s analysis of dysfunction is that which questions its presumed factual basis. For Wakefield, the norms underpinning natural function are natural (evolutionary) norms to be contrasted with social (cultivated) norms (Bolton, 2008, 124). The former underpin the objective status of dysfunction and the latter feature in the harm component. According to Bolton (2013), it is no longer possible to maintain a clear distinction between what is natural/innate and what is social/cultivated. It is now generally accepted that psychological functions are a product of an interaction between several factors: socialisation processes and genetic inheritance, complicated by individual differences and choice (Bolton, 2013, 442–3). These factors are not separable through the science we currently possess (Bolton, 2013, 442–3). Yet without a clear distinction, Wakefield’s account cannot tag exclusively onto a fact of our evolutionary nature in its bid to provide a value-free account of dysfunction.

If we accept the criticisms of these two leading naturalist theories, we can conclude that it has not proven possible to define function and dysfunction in value-free terms. We may accept this conclusion yet continue the search for a value-free, theoretical concept of function. An alternative position is to take seriously the value-ladenness of the relevant concepts and see where this may lead us. It will lead us to various forms of normativism about function. Here, descriptions of normal function are made in terms of what is good or bad, desirable or undesirable for an agent in the context of specific life situations and environments, in the present or a projected future. Those descriptions, though not pretending to have an objective standpoint in nature, are not any less “real” than naturalistic accounts: the core values that inform our lives, the projects we engage in, and the futures we plan are very serious matters. Indeed, it is a reflection of their seriousness that we tend to refer to those aspects of our abilities that may prevent us from pursuing

them as “diseases” or “disorders.” But, the apparent objectivity of these terms should not obscure that they signal a normative and not a natural limit; they signal the limit of what a person and/or society considers normal, valuable, or good. These notions are set against a background of abilities that are considered the norm, in the sense of being the taken for granted foundations of a particular way of life in a particular social and physical environment. This has implications on how we can talk about disability.

It will help at this point to recall the problem that led us here. It was borne out of the need to arbitrate between the medical and social views on the origin of the limitations associated with variations in function. Advocates of the medical model consider most of the limitations to be unconditional, i.e., intrinsic to the dysfunction/impairment/variation itself. Given the prior analysis, we have a different way of understanding this claim. When we witness a person struggling to achieve some complex goal, we may refer this back to some dysfunction in his or her abilities. Now, we can see that the limit drawn by our reference to dysfunction is a normative and not a natural limit. Hence, when we say that a dysfunction (or an impairment or variation) is intrinsically disabling, we need also to give an account of the norms, values, and contexts by which we were driven to make this claim, and to come to terms with that being the basis of our judgment. The importance of remaining cognizant of this point is that in its absence we would not even occasion the need to perhaps examine those norms, values, and contexts and see if they can be modified in such a way that would reflect positively on that person’s ability to function and thrive in society through various sorts of adjustments. This would act as a bulwark against the gratuitous individualization of the difficulties others face, and the powerful tendency to medicalize their predicament instead of coming to terms with the social solutions that can be put in place, bearing in mind that that is what the activists are asking for.

Before proceeding, a final clarification: this argument for a normative reading of disability judgments does not entail that we must in each case employ the social model, evidently not; in many cases addressing limitations through medical correction or, more generally, intervention at the personal level will be recommended. What it does mean, however, is that the judgment as to whether we should intervene at the individual or social level cannot be made through recourse to some account of natural function and dysfunction, but by pragmatic as well as ethical factors including considerations of efficiency, safety, equality, and justice to name a few.

V. APPLYING THE SOCIAL MODEL TO MADNESS

Having established the normative nature of disability judgments and having developed the first bulwark against the tendency to view certain variations/impairments in functioning as inherently disabling, it remains to be seen just

how the social model can be applied to madness. In the ensuing discussion, note that the concern is with conditions that are long-lasting, have a substantial effect on daily activity, and where treatment is either not desired or not possible, i.e., we are concerned with “disabilities” and not acute or self-limiting problems.

Applying the social model to madness is not new; activists and academics have written about the potential and the problems of doing so. The disability movement has achieved some progress in making salient the contributions of the physical and social environments to generating limitations, with many accommodations to address this now enshrined in law. Developing a social model of madness in keeping with the social model of disability is seen as a way of counteracting the “medicalized individual approach” that is dominant in society and mental health institutions (Beresford, 2005; see also Mulvany, 2000). Resistance to this proposal has come from both sides. Some psychiatric survivors/service users refuse to be associated with disability discourse, as they do not consider themselves to have an impairment, nor do they want to be associated with the “pathologising” implications of the term “impairment” (see Beresford, 2000; Beresford et al., 2010). Conversely, others actively endorse the term disability as it creates a sense of community across the survivor/service user/mad and disability movements (Price, 2013). Yet, others are reluctant to use “disability” for the fear of being accused that they are not disabled enough; that they do not have the appropriate life-long impairments (Spandler and Anderson, 2015, 24). The reluctance of some within the Mad movement to accept the social model of disability and adopt its terminology has been interpreted by a physically disabled activist as reflecting the “disablism” prevalent within sections of this movement (Withers, 2014). That is, in refusing to be referred to as disabled and in asserting that unlike disabled people they have no tangible, “real” impairment, these activists are contributing to the idea that disability is a fixed thing and not an outcome of the interaction between individual capacities and specific social/physical contexts. Fear of increased stigma is another stumbling block for a shared discourse and activities between the disability and the Mad movements. Each group faces its own distinctive stigma in society, and to take on the term “madness” or the term “disability” is to take on an extra challenge (Withers, 2014).

Although these are important issues, the key point for the argument here is the underlying framework and not the terminology in place: what is of essence in the medical/social model framework is an account of the interaction between the individual and society in relation to the production of limitations on everyday activity. With regard to naming, one may eschew the problematic term “impairment” for the less-loaded one “variation,” and one need not use the word “disability” at all. On the question of what constitutes a mental variation we don’t need to assume some account of natural function by which mental functions (and variations thereof) can be

specified—the idea of natural function has already been problematised.¹⁵ Given the argument presented earlier, a relevant mental variation is one that is made salient when our complex activity in the world is disrupted. It would not be “schizophrenia” or “psychosis,” but the features that typically underlie these diagnoses such as voices, paranoid beliefs, anxious feelings, difficulties understanding social behavior, mood fluctuations, impaired attention and concentration, and others. These features can impose a range of limitations on the ability of individuals to realize their goals and to participate in everyday social situations and interactions. A few examples will illustrate:

- A person who experiences chronic anxiety (or paranoia) finds it difficult to negotiate the long, crowded, bright lanes of the local mall and heads home without shopping. We can look at this disruption to activity from two vantage points: as a problem with the world or as a problem with one’s mental state (anxiety). Wherever we start, the other vantage point is implied: the difficulty of negotiating the mall makes salient my anxious feelings; my anxious feelings make salient the difficulty of negotiating the mall.
- A person hears voices and converses with them, as she finds this helpful and affords her a measure of control. When she does this in public people give her strange looks and sometimes walk away from her. Due to this, on many days she feels unable to leave the house and her social isolation is increasing. Here, as with the previous example, the disruption to activity (social isolation) can be seen as a consequence of one’s behavior or due to negative social responses, with each view made salient by the other.
- A person experiences fluctuations in mood; when “high” he can work for many hours on end, frequently overnight. Such episodes are followed by several days of rest during which he feels tired and low in mood. Due to this, he is unable to keep consistent employment as his line of work cannot accommodate the requirement for erratic working hours. In this case, disruption to activity (employment) can be seen as a consequence of his mood fluctuations or due to unaccommodating working arrangements.

In each case, once a specific mental variation is identified, it becomes possible to reflect on the variation/environment mismatch and to formulate more precisely what exactly needs to change: modify the mental state/behavior, alter the environment, or some combination of the two.

The issues are different when the variation in question consists in a strongly held, nonconsensual belief: a “delusion.” For the sake of exposition consider two paradigmatic examples: the belief that one is persecuted by certain agents (persecutory delusion) and the belief that one’s spouse has been replaced by an impostor (Capgras delusion). On the basis of such beliefs, the person holding them may, respectively, barricade himself at home or

avoid the spouse.¹⁶ For an outside observer who can see that both beliefs are false, those individuals are subjecting themselves to unnecessary limitations; they are disabled by their beliefs. But for the believers themselves, this insight would not arise as long as they continue to hold the requisite belief with conviction.¹⁷ For them, the problems they experience are facts about the world—that one *is* unsafe and that one’s spouse *is* an impostor—and not the beliefs per se. In terms of the basic idea underlying the social model, as argued in Section IV, what is made salient by what appears to be disruption to daily activity is not one’s mental state, but facts about the social world. If I refuse to leave the house because someone is waiting outside for me with a gun, I am not disabled; I am sensible. If I am convinced that I am under threat despite there being no threat, then others may consider me disabled by my belief, but I would not. In this specific respect, “delusional” beliefs are outside the scope of the social model. They are brought back within it, however, in a different manner.

The “delusional” person may experience limitations of a different sort. He or she may experience discrimination, disqualification, and ridicule for the very fact of holding the belief(s) in question. In this respect, the discrimination in question would be no different to that which some religious minorities or sects face, except in relation to the question of numbers; the delusional person goes it alone, whereas sects tend to have a larger following. Here, we are brought back within the scope of the social model, as I am prevented from accessing the same rights and respect as other citizens due to the beliefs that I hold. A remedy could be to change the belief or, alternatively, to change the social environment by making it more accepting and tolerant.¹⁸

The earlier examples show that even though the issues are complex and will require conceptual work and ingenuity, it is possible to apply social model thinking to at least some mental variations and related behaviors. In fact, this approach to mental variations has made its way to a number of publications by academics, policy makers, and charities in the United Kingdom and elsewhere.¹⁹ These publications have issued recommendations on reasonable adjustments in the work place for people with “mental disabilities.” Underlying this is the understanding that by contrast to physical impairments, mental variations tend to be less visible, have a more significant impact on the social rather than the built environment, and hence will require adjustments that focus on social interactions and relationships (Department for Work and Pensions, 2009). Among the recommendations: time-out if one feels anxious or paranoid, flexible hours, reduced workload, quieter workspace, private rather than open-plan working arrangements, availability of contact with a support worker or friend if someone feels particularly paranoid, working conditions matched to a person’s tolerance for contact with large numbers of people, and combating stigma among colleagues at work. The mental health charity [Rethink Mental Illness](#) (2012,

9) goes further, stating that stigma and negative attitudes of colleagues “can undermine adjustments that would otherwise be effective.”

Rethink is exactly right to point toward stigma as a major issue: without some significant change in how people think about madness/mental health problems, any proposed adjustments will be superficial and of limited effectiveness. Further, stigma and negative perceptions may impact on individuals’ self-esteem and psychological and emotional well-being, thus creating further barriers to participation.²⁰ Yet in pushing to alter such attitudes, the [Department for Work and Pensions \(2009\)](#) and [Rethink Mental Illness \(2012\)](#) advance or support the line of thought that mental health problems are illnesses akin to physical illnesses, in the sense that they occur for reasons outside a person’s control (which arguably reduces blame), can be treated, are not to be feared, and are not a sign of weakness. However, as an anti-stigma strategy, this is problematic on two counts: first, studies have shown that the argument that “mental illness is an illness like any other” does not reduce stigma, in fact it is associated with perceptions of unpredictability, dangerousness, and fear ([Read et al. 2006](#)); second, this argument is antithetical to the demand for recognition of madness as an identity, where concerned groups do not see themselves as ill and where aspects of madness are reformulated in a positive light or, at least, neutrally. Rethink is correct in pointing out that negative attitudes can genuinely hamper a person’s ability to partake in the work environment; the difficult question is to specify what lies at the root of the problem in society at large.

To put this differently, impaired concentration, anxiety, paranoia, and social withdrawal are experiences that are commonplace enough not to generate any severe or unique discrimination from others. Most people are familiar with these experiences—think of sleep deprivation, jet lag, or a bad hangover—and readily find excuses for each other for them and, if they are generous, accommodate each other for them. What generates particular challenges in the case of madness is precisely the association of such experiences with phenomena that generate fear and distrust in others. To be anxious or paranoid due to the effects of alcohol overuse is not the same as having those experiences due to hearing voices or harboring fears that one is persecuted by government agencies or by invisible beings. The latter are phenomena that, for most people, defy simple, if any, meaningful explanation and from there engender a certain kind of disqualification and possibly distrust grounded in the apparent unintelligibility of these phenomena. At the point where this occurs, it is hard to sustain a social interaction in which the unique variations and traits of a person are noted and respected in order to create for him or her a more accommodating environment. More likely than not, when unintelligibility sets in we move from a position of accommodation to one of seeing the person before us as the main cause of their struggles. Intelligibility, therefore, is an important idea and merits a further look.

VI. INTELLIGIBILITY AND THE LIMITS OF SOCIAL ACCOMMODATION

There is no doubt that the variations discussed in Section V differ in significant respects when compared with mobility and sensory variations in relation to the question of social accommodation. One difference, noted by [Pilgrim and Tomasini \(2012, 634\)](#), is that at the heart of the social reaction to “mental health problems” is an “attributed loss or lack of reason.” By contrast, with mobility and sensory variations (physical disability more broadly), that capacity is not at stake. Assumed lack of reason, they continue, underpins the disadvantage and discrimination that characterize the social response to madness; it underpins fear and distrust as well as paternalistic limitations of autonomy. Unreason here is used quite broadly and ranges from not being able to meet social obligations (due to anxiety or depression) to failures in intelligibility exemplified by individuals whose behavior is underpinned by voices, bizarre delusions, thought disorder, or other states that for some may resist everyday understanding.²¹ Intelligibility emerges as a helpful concept in marking out more precisely an important, if not central, factor that determines the limits of social accommodation of difference: the point at which we cease to consider discourses of social adjustment in favor of those that describe, in various ways, some sort of failure in the individual, for example, that he or she is “mentally ill.”

Consider the experience of hearing voices and its impact on behavior. A “voice-hearer” ([Woods, 2013](#)) may at times converse with the voices and be distracted by them. In some social contexts, as indicated earlier, behaving in this way can generate negative responses from others that may lead the voice-hearer into isolation and fears of appearing in public. In this example, developing social narratives in which voice hearing is normalized or marked out as a unique experience can engender a measure of intelligibility and tolerance of the associated behaviors, and this in turn may improve social inclusion for the voice-hearer. As [Spandler and Anderson \(2015, 19\)](#) note, this is what the Hearing Voices Movement has been seeking to do: to affect a shift from the view of voices as symptoms of illness to that of voices as meaningful phenomena. Intelligibility will depend on the kind of narrative put forward to create this meaningfulness. Some narratives draw connections between voice hearing, spirituality, and nonhuman agents such as spirits. Others see voices as denoting aspects of self and hence as offering a means for a more profound understanding of one’s past and identity.

For the voice-hearer’s interlocutor, intelligibility will depend on the extent to which he or she is able to accept the assumptions supporting the different narratives. And, herein lies the challenge of expanding our limits of the social accommodation of difference and our ability to conceive social adjustments: madness asks us to question our total worldview; to question our beliefs, values, sense of self, ideas of rationality, and personhood.²² The change required here is not to install a ramp or an alternate sign, it is to

change notions fundamental to us as persons and to broaden the idea of what is possible. This is most evident in cross-cultural encounters. Consider, for example, a person who barricades himself at home on hearing the voice of a spirit threatening him with death if he leaves his house. Whether we consider this an “illness”—after all it appears to be a paradigmatic example of “action failure”—or a genuine threat, will depend on the extent to which we take the cause of the obstruction as real.²³ In cultural contexts where spirits are considered to exist and to have a say in human affairs, that person’s self-imposed incarceration may appear to others as a sensible course of action until the spirit is dealt with. In cultural contexts where the “spirit” is understood as alienated mental content—objectified aspects of self—that person may be considered “ill.”

While we are on the theme of cross-cultural encounters, we can consider other phenomena that appear to *really* defy intelligibility across cultural contexts. Such phenomena, thought disorder, for example, do not enjoy the “collective reasonableness” and positive reframing achieved by, say, the Hearing Voices Movement (Pilgrim and Tomasini, 2012, 642; Spandler and Anderson, 2015, 18–9). Jones and Kelly (2015, 47), mental health activists and academics, assert that “the struggles of a distressed individual who can nevertheless communicate with others, can and must be distinguished from an individual with thought disorder so severe that he or she can no longer be understood, even in the most basic of ways.” For Jones and Kelly, the limit of intelligibility is thought disorder, which is the limit it would appear of thought itself. For other less accommodating individuals, the limit lies much earlier, being evident for them in the slightest eccentricity in belief or behavior. The limit of intelligibility lies at different places for different people and, as indicated previously, marks out the point at which we begin to consider the limitations experienced by an individual to flow from the variation itself. At this point, we cease to consider changing social behavior in favor of changing the individual.

There are two bulwarks against this move or, at least, against assuming it too readily. The first has already been mentioned earlier and concerns the need to specify the values and standards by which one was driven to regard a particular variation as intrinsically disabling. In doing so, one may give more thought to the possibility of changing those standards in a way that would permit a broader accommodation of difference. The second bulwark arises from political activism: from the very demand for social justice raised by activists.

VII. POLITICAL ACTIVISM AND THE SOCIAL SUBJECT

Mad Pride activists demand change in the social beliefs, norms, values, and overall practices that define madness/mental illness—essentially society’s total understanding and treatment of these “conditions.” The expectation is for society to change to accommodate a unique identity or culture. Hence, a major

site of change is the reductive, discriminatory, and disrespectful language that dominates public and professional narratives, a language in which key terms all indicate deficit and pathology: disease, illness, disorder, delusion, hallucination, and, of course, “madness” itself before its reclamation by activists. In this respect, Mad Pride’s demands lie on a par with demands for recognition long voiced by the more familiar collective identities constructed around race, gender, and sexuality. Indeed, as indicated at the outset, the analogy with Gay and Black rights is central to the discourse and is frequently pointed out. In urging cultural change, the demands of Mad Pride go beyond the equalization of civil rights irrespective of difference (which requires a politics of equality that rejects discrimination on the basis of morally irrelevant features) but, rather, the recognition of that difference *as a matter of social justice*: the distinctness of the identity in question, its claim to respect and equality.

The demand that society should change to accommodate a broader range of variations as a matter of justice implies that the person making this demand is a social subject. What is meant by “social subject” will shortly become apparent, but as an approximation it can be taken to mean a human being who sees oneself and sees others as engaged in a shared project in which each individual’s well-being is at stake and equally matters. Now at first sight, this claim may appear paradoxical, for a popular view in both lay and scholarly accounts is that a central aspect of madness (or of “schizophrenia”) is the *dis-sociality* of the subject; a sign of mad subjects’ madness is their withdrawal from society. For example, a person with severe paranoia may have a radical, sometimes global, loss of interpersonal trust; for that person, others appear not as co-participants in a shared project but as a threat to one’s existence. In a related manner, the phenomenological psychopathology literature describes the “schizophrenic” person as having a crisis of intersubjectivity; a disruption to the two fundamental poles of social reality: *sensus communis* and attunement.²⁴ Other times the “schizophrenic” person is described as having a disorder of consciousness and self-awareness; an ipseity disturbance characterized by hyperreflexivity and diminished self-affection (this view also concerns the “schizophrenic” person’s dis-sociality but starts from subjectivity rather than intersubjectivity).²⁵ These accounts may seem to invalidate the idea that the “schizophrenic” person can be a social subject in the sense described earlier. If one accepts this conclusion, how do we make sense of those making the demand for social justice? One (cynical) approach is to claim that Mad Pride activists are not really mad at all. Another approach is to argue that the issue here is a matter of scope: the phenomena referred to by phenomenological psychopathology are at the far-end of the spectrum of sociality and are not representative of all “schizophrenic,” “psychotic” or mad experiences.²⁶ I reject the first approach and accept a qualified version of the second, as will be evident in what follows. But first, I return to the idea of the social subject implied by the demands of activists.

Implied by the demand for the accommodation of a broader range of variations as a matter of justice are, at least, the following:

- An understanding of oneself as an individual among others.
- An understanding that individuals are different in some respects from each other, i.e., human diversity.
- An understanding that individual well-being depends, in part, on the sustenance provided by social interactions and arrangements.
- The ability to see oneself as part of a smaller group that is part of wider society.
- An understanding of oneself as a person who possesses rights and whose claims merit recognition.
- An understanding that others too possess rights (this is already implied by the way in which the demand is couched in the language of justice and fairness).

In short, what is implied by the demand is a view on social justice and an understanding of society. Returning to the limits of intelligibility discussed in Section VI, we can say that by virtue of making this demand—notwithstanding the unintelligibility of specific experiences or behaviors—the person should be seen as a candidate for the social accommodation of difference rather than the medical (individual) correction (treatment) of behavior; the demand should act as a bulwark against the prioritization of an individual approach. The reason this is so is that the demand trumps the objection against social accommodation. In the terms raised here, this objection can be put as follows: mad individuals are, as it were, outside society, and to argue for accommodating their behaviors and mental variations is to risk losing society altogether, grounded as it is in shared rules and assumptions. The political demand demonstrates the person's sociality and appreciation of the shared meta-project that is society, and hence refutes this objection.

Returning to the point I made earlier concerning the scope of sociality, it is true that some mad (or “schizophrenic”) experiences *appear* incompatible with sociality, a point made in phenomenological psychopathology. However, I see those whom phenomenological psychopathology describes as suffering with a crisis in intersubjectivity to be those subjects who are yet to see their situation in terms of identity, diversity, and social justice; who are yet to be brought to a conception of themselves as social subjects. Here, the principle of consciousness-raising that is described in the activist literature is instructive. This is the process by which people get together, share stories, see similarities in their situations, and interpret their predicaments as arising from discriminatory and difficult social conditions rather than individual pathology. Once this is achieved, a demand is made to change those conditions. Given this, an actual key goal within activist communities is to support individuals such that they are able to make that demand. In this endeavor, creating “collective reasonableness” in relation to particular phenomena is

also crucial. It may not be possible for some individuals to make the demand despite such support, and for others they may not wish to make it, opting instead for a more individual, illness-based discourse and intervention. But by redescribing the problem of sociality as a problem to be partly worked out in activism and political action, we are able to erect a bulwark against the tendency to see it in terms of disorder and individual pathology.

VIII. CONCLUSION

Along the decades, different groups have campaigned and struggled for respect and rights; some have been successful at achieving symbolic and cultural reparation, others less so. The enlarged scope of Gay rights in parts of North Europe, North America, and a few select other regions is usually cited as a success story. It is now pointed out that societies need to come to terms with the rights of transgender individuals and the respect they may be owed. Yet, Mad individuals, and madness more broadly, are yet to feature in the conversation on respect and identity, a conversation still dominated by framings that emphasize the medical idiom and the notions of distress and disability. This paper sought to address the problem of disability by erecting two bulwarks against the tendency to assume, too readily, a medical interpretation of the limitations experienced by individuals with the kind of variations in mental function that fall under the umbrella term “madness.”

The first bulwark arose from an analysis of the disability model that revealed the normative basis of disability judgments: when we say that a variation (or impairment) is intrinsically disabling we need to accompany this judgment with an account of the values, norms, abilities, and contexts that underpin it. This requirement, though it may appear too subtle to make a difference, actually brings about a profound change in perspective: instead of seeing the limit of our ability to understand and accommodate difference as an indication of a (natural) problem with the difference itself, we come to view it as a normative limit constituted by values, norms, and abilities that go so deep they appear natural. With this insight in place, it becomes possible to resist medicalizing difference, and reflect on what possible social solutions can be put in place to accommodate it.

The second bulwark arose from reflection on the implications of political activism. To demand, as a matter of social justice, that society changes to accommodate a broader range of variations in function is to be a social subject; it is to be a candidate for the accommodation of difference rather than the individual (medical) correction of behavior.

There is no question that effecting the recommended change in perspective is a challenging endeavor. Although applying social model thinking to mental variations (to madness) is possible—as I have demonstrated—it raises issues different from the kind of variations in physical function for

which the social model of disability was initially developed. A key difference is the way in which madness presents a challenge of intelligibility; it asks us to question and broaden our values and beliefs with respect to fundamental notions such as our sense of self and overall worldview. Difficult though as that may be, at least we can now come to view this (apparently) insurmountable difference for what it is: as a radical challenge to norms and concepts constitutive of who we are. Whether we should attempt, as a matter of moral obligation, to change these norms and concepts in order to accommodate a broader range of experiences and behaviors is a further question to be considered.

NOTES

1. This paper is based on a larger research project in [Rashed \(Forthcoming\)](#). Parts of this paper will appear in the book.

2. For accounts of Mad Pride written by activists consult [Curtis et al. \(2000\)](#), [Costa \(2015\)](#), [Sen \(2011\)](#), [Triest \(2012\)](#), [deBie \(2013\)](#), and [Smiles \(2011\)](#). See also *Asylum Magazine* (UK), Spring 2011, Mad Pride issue, Volume 18, No. 1. For records, flyers and announcements of past, recent and upcoming Mad Pride events consult the following websites: *Hamilton*: [<http://madpridehamilton.ca/>]; *Toronto*: [<https://madprideto2015.wordpress.com/>]; *Liverpool*: [<http://www.liverpoolmentalhealth.org/mad-pride/>]; *International*: [<http://www.mindfreedom.org/campaign/madpride/events>]. See also: Mad Pride issues of the Consumer/Survivor Resource Centre of Canada Bulletin (online: <http://www.csinfo.ca/bulletin.php>). Note that Mad Pride is capitalized to denote a group identity much like Gay Pride, for example. All links functional on July 19, 2018.

3. See [DuBrul \(2014\)](#), and the ICARUS project website, online: <https://theicarusproject.net/mission-vision-principles/>

4. Elsewhere, I have explored, with Rachel Bingham, some of the issues raised by the concept of distress in relation to the distinction between “social deviance” and “mental disorder” ([Rashed and Bingham, 2014](#)).

5. The term “well-being” is used here in a colloquial, non-technical sense.

6. See, for example, the [UK Equality Act \(2010\)](#), the [US Americans with Disabilities Act \(1990\)](#), and the [United Nations Convention on the Rights of Persons with Disabilities \(2006\)](#).

7. See [Silvers \(2010\)](#) for a good philosophical overview of the social model of disability.

8. Note the difference between a person born with a sensory inability—blindness, for example—and a person who loses sight as an adult. The latter experiences a radical change in functional capacities that may be very distressing and disabling and may take some time to adapt to. On the other hand, a person born blind may not necessarily experience blindness as a salient obstacle in everyday life. This may change, however, if that person wishes, for example, to seek employment or further his or her independence. At that point, not being able to see in the context of a physical environment that does not take this particular sensory inability into account, may generate disability.

9. It is possible for a particular state to become salient without resulting in disruption to daily activity; a twisted ankle may cause pain and discomfort without rendering the sufferer immobile. Similarly, one may experience sadness, paranoia, or anxiety without this limiting social interaction or activity. However, the discussion in this section concerns disability, and the issue is disruption to activity.

10. A possible objection to this point is that a person with paraplegia and no recourse to a wheelchair may find it very difficult to move from point A to point B. Here, he is clearly thwarted in realizing his goal and the obstruction is not a consequence of unaccommodating social arrangements. However, disability theorists who endorse the social model for mobility impairments begin their argument by assuming the presence of a wheelchair. Disability consists in the limitations faced by the wheelchair user in environments with limited stair-free access. Critics could object that you cannot assume the wheelchair as it is not part of a human’s natural embodiment. Once you remove the wheelchair, they could argue, the extent of non-socially imposed disability becomes evident. A response to this objection is to think of the

wheelchair as a tool that improves the functional abilities of persons who cannot walk. If I come across a 1-ton boulder and find myself unable to push it out of my path, I face a limit to my functional capacities, but I do not thus conclude that there is a disorder with my abilities (unless I am Hercules). To move the boulder, I make use of tools either to break it down to smaller parts or to somehow push it out of the way. Human beings use tools throughout the day to help them compensate for their functional capacities and accomplish tasks that otherwise would not be possible. The wheelchair is a tool in this sense, and it is acceptable to assume it as a given in arguments concerning the social basis of disability.

11. Note that the focus here is on the generation of disadvantage (limitation) and not on the factors implicated in the genesis of the variation/impairment in the first place, which can include various psychological, biological and social factors.

12. Unconditional disadvantages are referred to in the disability literature as “impairment effects.” These include the discomfort, pain, and inabilities, which disabled people face and are distinguished in the literature from the disadvantages experienced as a consequence of social restrictions and discrimination (Thomas, 2004).

13. Reference classes are included by Boorse to account for the wide variation of function within *Homo sapiens*: normal function in a newborn would not be the same as an 8-year-old child.

14. There are many critiques of naturalist accounts of (dys)function; the following are particularly helpful: Boorse (2011, 26–37) for a summary of the theories and the objections; Bolton (2008) presents a short critique of Boorse’s theory and a substantial analysis and critique of Wakefield’s; Kingma (2013) contains an overview of both theories and a general critique of naturalist accounts of disorder.

15. There have been some recent calls to adopt the discourse of “neurodiversity” as a positive replacement for the language of “impairment” (Graby, 2015; see also McWade et al., 2015). Advocates of this move believe that this would bring about a positive change: instead of “impairments” we would have a diversity of “minority neurotypes” that stand alongside so-called “normal neurotypes” as real and valid neurological types. These neurotypes, it is argued, should be accommodated as an element of diversity such as race or ethnicity. A major problem with the neurodiversity discourse is that it assumes that existing categories and identities (e.g., Autism, Attention Deficit Hyperactivity Disorder, Normal, and Mad) can be traced back to a shared “neurology.” But, our identifications and categorizations of behavior—as is now generally accepted in the domain of mental health—do not “cut nature at the joints” or reflect natural discontinuities. If so, then there is not much sense in the claim that there are distinct neurological types essentially different from each other. Further, neurodiversity raises a number of difficult questions; for example: what exactly is a “normal” neurotype? Do all “normals” share one neurotype? Do all people with “autism” share one neurotype? Neurodiversity may be important from an activism point of view, but as an argument it does not work.

16. Not all “deluded” individuals act on their beliefs, a phenomenon known as double bookkeeping (see Sass and Pienkos, 2013, 646–50). An oft used example is that of the man locked in an asylum who believes he is Napoleon yet does nothing toward exercising his regal powers.

17. This can change if the person develops primary insight into the delusional nature of the belief; if he or she is able to see that it is false, that he is not persecuted and that her husband is not an impostor. In such cases the person loses conviction in the belief and is able to see that it really was determining behavior in limiting ways.

18. Making society more tolerant is a solution that tends to be pursued in communities that advance notions of free speech and multicultural acceptance. The flip side of this tolerance is for the groups in question to develop secondary insight (a point which also applies to the “delusional” person). Secondary insight refers to subjects’ abilities to see their beliefs from the point of view of common social values and norms, and in doing so to see that others may find those beliefs unusual or bizarre. The benefit of secondary insight is that it introduces appreciation of what others’ views are without requiring agreement with those views. It allows contrasting beliefs to exist side by side, with both groups remaining aware that it will be difficult to reconcile those beliefs with each other. This is to be contrasted with primary insight, which as a notion in psychiatric practice refers to the person conceding the falsity of her (delusional) beliefs and demonstrating awareness that she is “ill.”

19. See Heron and Greenberg (2013), Thornicroft et al (2008), Goering (2009), the UK Department for Work and Pensions (2009), and the mental health charity Rethink (2012). Of note is that the UK Department of Health now recognizes as a disability a mental health condition that lasts more than 12 months and affects normal day-to-day activity. Among the listed conditions that may lead to disability are schizophrenia, depression, and bipolar disorder. By being classified a disability, a mental health condition falls under the protection of the Equality Act (2010) and the United Nations Convention on

the Rights of Persons with Disabilities (2006). According to these acts, the state is under an obligation to provide individuals with disabilities the chance to participate fully in all aspects of life through provision of reasonable adjustments that promote access to and engagement with the environment.

20. This is referred to in the disability literature as psycho-emotional disablism (see Reeves, 2015).

21. In each of these cases intelligibility means something different. With voices, the issue may be that such experiences are completely alien given my worldview. With bizarre delusions, I may be struck by how patently false these claims are or fail to understand why this person is holding them. With thought disorder, there may be a more basic inability to grasp any meaning at all in what a person is saying. The point here, however, is not to parse out the different forms of failure of understanding (see Rashed, 2015), or to suggest ways of enlarging intelligibility.

22. In contrast, mobility and sensory impairments ask us, primarily, to question our embodiment. I say primarily because many physical conditions also generate huge stigma—human immunodeficiency virus (HIV), for example, or leprosy—and hence also implicate the self of patient and other.

23. It would constitute action failure in so far as it is a negatively evaluated experience of incapacity, where incapacity is defined as a failure of intentional action (Jackson and Fulford, 1997, 54). The example provided fulfils the two requisite elements for action failure: (1) there is a failure of intentional action (the person is unable to make his will effective and not due to an external cause). (2) This incapacity is negatively evaluated. (See also Rashed, 2010, 189–90.)

24. This account is found in a number of works, particularly the work of Giovanni Stanghellini (2004).

25. This account is found in the work of Louis Sass, Joseph Parnas, and others (see Parnas and Handest, 2003; Sass, 2003; Sass and Parnas, 2007).

26. A third approach is to cast doubt on the methodology by which the conclusions of phenomenological psychopathology are reached (see Rashed, 2015).

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