Madness, Disorder, and Society

Note: Both conference rooms are in Square 1 in the Colchester Campus at the University of Essex. Room A, the Senate Room, is in the Psychology building and Room B, 1N1.4.1, is next door in the Computer Science and Electronic Engineering building.

Schedule:

9:30-10:00- Registration and tea/coffee (Room A: (Senate Room; 4.722))

10:00-11:30- Keynote Presentation from Dr Lorna Finlayson (Essex), TBA (Room A; Senate Room)

11:45-13:15- Parallel Sessions 1:

Panel 1: Neurodiversity and its critics (Room A; Senate Room)

Mad Problems: A Critique of Mere Difference Views in Psychiatric Disabilities Rights Groups by Samantha Hirshland (Boston)

Autism, Neurodiversity, and the Question of Suffering by Robert Chapman (Essex)

Panel 2: Existential Perspectives (Room B; 1N1.4.1)

The Importance of Being Anxious by Darshan Cowles (Essex)

Schizophrenia, Loss of Grip and Delusional Stabilization by Philip D Kupferschmidt (Leuven)

13:15-14:15- Lunch

14:15-15:45- Parallel Sessions 2:

***Panel 3: History and Culture* (Room A; Senate Room)**

The Lobotomy as Medical Social Control: Psychosurgery, reason and emotion, gender and deviance by Alex Serafimov (Nottingham)

Phenomenological approaches to mental illness across cultures: A case for Iranian Dysphoria by Moujan *Mirdamadi* (Lancaster)

Panel 4 – Unreason and Madness in Society (Room B; 1N1.4.1)
Paper 7 - *Listening to Unreason: Foucault and Wittgenstein on Reason and the Unreasonable Man* by Liat Lavi (Bar-Ilan University)

The Necessity of Oblivion: Schopenhauer and Nietzsche on the Madness of Normality and the Normality of Madness by Paul Stephan (Frankfurt)

15:45-16:15- Tea/Coffee

16:15-17:45- Keynote Presentation (Room A; Senate room) *Whose Norms are they Anyway? Theorising the Concept of Mental Disorder* by Professor Derek Bolton (King's College London)

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Note: Tea and coffee with be provided and for lunch there are various outlets on campus where meals can be purchased. The conference will be followed by drinks in Topbar and then, for those who have booked, a meal in Wivenhoe House (both are situated on Campus).

Abstracts

- ***Listening to Unreason: Foucault and Wittgenstein on Reason and the Unreasonable Man*** **by Liat Lavi:**

Both Foucault's *Histoire de la Folie* and Wittgenstein's *On Certainty* can be read as investigations into the grounds of reason. The two offer quite different and distinct perspectives on the matter, and yet I suggest that they share some central insights and that their views are to a large extent complementary. In both we find that the boundaries of reason are not only vague but are also largely founded upon the relations (social in Foucault, socio-linguistic in Wittgenstein) between the reasonable and the unreasonable man. Both perspectives also reveal a curious state of affairs, whereby the reasonable man is the one who dominates discourse, and yet he is forever dependent upon the unreasonable man and his rejection. In a sense we could say that it is rather the reasonable, which is negatively defined that which is 'not unreasonable'.

Foucault and Wittgenstein are both critical of the dichotomous conception of reason, and present their views, at least partially, as criticisms of Descartes' reaction to doubt. The pressing question triggered by Foucault's account is whether the boundary between reason and unreason (in Foucault, *déraison*) is at all necessary, and whether we can conceive a world of discourse largely lacking it. Wittgenstein seems to answer this question in the negative. Flexible, praxis-based and context-dependent as it may be, this salient boundary remains in Wittgenstein logically necessary for the very possibility of discourse. I argue in this paper that Wittgenstein's criticism of Cartesian skepticism presented in his *On Certainty* loses much of its fortitude once examined in light of Foucault's *Histoire de la folie*.

- ***Autism, Neurodiversity, and the Question of Suffering*** **by Robert Chapman:**

According to the influential *American Psychiatric Association* (APA), a mental disorder is 'a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning'. Moreover, it is stressed, mental disorders are 'usually associated with significant distress in social, occupational, or other important activities'. In short, then, to count as a mental disorder, a syndrome has to impair functioning, cause suffering or distress, and stem from *inside* the individual. One such disorder listed by the APA is Autism Spectrum Disorder (ASD). The APA suggests a behavioural diagnosis of ASD based on social and communication problems alongside restricted and repetitive habits, actions, and routines. In the broader medical literature, autistic behaviours are taken to stem from deficits in what is variously called 'cognitive empathy' or 'theory-of-mind' alongside more general sensory-processing issues. This relationship between cognitive deficits and functioning impairments supports the notion that ASD stems from inside the individual, making it a paradigmatic mental disorder on the APA's model.

Nonetheless, against the notion that autism is a mental disorder, proponents of the 'neurodiversity paradigm' argue that autism is not a deficient way of functioning, but rather a different kind of functioning that is unduly pathologised for ideological rather than medical reasons. Drawing on the social model of disability, which locates disability in society rather than in the individual, proponents of neurodiversity argue that the problems autistic people encounter are due to structural, ideological, and normative biases in society rather than anything inherent in those individuals deemed sick. On this view then, autistic people have neurological disability due to being a minority neuro-type, rather than a disorder that reflects something inherently pathological within autistic individuals.

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Both camps agree that autism stems from inside the individual and alters functioning. Given this, whether we should consider autistic functioning to be deficient or merely different comes largely down to the notable amount of *suffering* or *distress* that autistic persons seem to encounter. Notably, even when we consider Asperger's syndrome – often referred to as the 'mildest' kind of ASD – the majority experience anxiety or depression, with approximately 90% having considered suicide. On the face of it, such evidence seems to provide strong support for the notion that autism is inherently problematic. Nonetheless, on a closer inspection, I argue, the association between autism and suffering may be the outcome of a sustained 'looping effect' that continually constructs the condition in an unduly oppressive way. On this view, I suggest, locating the causes of autistic suffering *inside* autistic individuals may not just be misguided but may in fact amount to victim blaming. Paradoxically, then, I conclude that the apparently greatly increased suffering experienced by autistic individuals may provide support not for the medical paradigm – but rather for the more radical claim that autism is not, in fact, best thought of as a mental disorder at all.

- ***The Lobotomy as Medical Social Control: Psychosurgery, reason and emotion, gender and deviance*** **by Alex Serafimov:**

Many have noted how reason and emotion have often been posited as opposites in Western philosophy. In this dualistic view, emotions are seen as distorting, clouding and disturbing our reason. As a society which highly values reason, emotions thus needed to be kept under control. Indeed, some have gone as far as arguing that one of the main aims of Western civilisation has been the "taming" of the emotions for the sake of order, progress and the domination of nature. To such ends, societies employ different emotion "regimes" which prescribe what kind of emotional display is appropriate or desirable in their subjects. An excellent example of how mainstream psychiatry participated in the enforcement of our own strict emotion regime, by aiming to achieve emotional "normality" in those it labelled mentally ill, was the psychosurgical procedure of lobotomy. It, and operations like it, would be carried out on over 50,000 people in North America by 1954 and around 15,000 in the UK alone by 1962. Entering the brain through burr holes and 'cutting into the nerve pathway connecting the frontal lobes (the "seat of reason")… to the thalamus (the seat of "emotion"),' lobotomy was said to alleviate mental illness by depriving "abnormal" thoughts of the morbid emotions that had been sustaining them. Simply put, 'the purpose of the operation is to break the connection between the patient's thoughts and his emotions.' Following this, patients 'can go outward into their fields of rational endeavor, their intellect unharmed, their emotions under control.' The story of lobotomy does not end there, however. In what could be described as a kind of medical "mission creep", there is evidence that lobotomy also policed other social norms in, perhaps unexpected, ways. These included various gender norms, the ability and desire to labour, a patient's political views and even the maintenance of the nuclear family and the prevailing social order more generally. In examining these cases, this paper will give special attention to the experiences of women, as they made up two-thirds of lobotomy cases, and seemed special "targets" of the procedure. In many chilling examples, disgruntled husbands are described as coercing their wives into the operation in large part because the women were seen as failing in their various duties of being an emotionally stable wife, mother and housekeeper. Thus, informed by Foucauldian and feminist approaches, it will be argued that lobotomy functioned as a radical form of medical social control, understood as the ways in which medical means are employed to minimise, eliminate, or normalise deviant behaviour.[1] This is argued through an in-depth and critical discussion of the philosophical origins of the reason/emotion dualism in Western philosophy, the theory behind the lobotomy procedure, and illustrated through various patient case histories. Lastly, the open question will be posed whether other somatic and pharmacological treatments, many in use today, bear any recognisable marks of the "logic" and rationale behind the now infamous and discredited lobotomy procedure.

- ***The Importance of Being Anxious*** **by Darshan Cowles:**

Anxiety, as generally understood, is an undesirable, unpleasant experience of extreme concern or worry. If persistent or severe enough, this experience can be debilitating, and is considered

[1] Conrad, P. and Schneider, J. W. *Deviance: From Badness to Sickness* (Mosby 1980), p. 242

pathological. In the DSM-5, anxiety is given as a symptom of several mental disorders, and is considered a mental disorder in its own right in the form of 'Generalised Anxiety Disorder'. Yet within a certain philosophical tradition, anxiety is characterised as definitive for human existence, and has been heralded as having important disclosive and transformative powers for those who experience it. In particular, anxiety plays such a role in the early philosophy of Martin Heidegger. For Heidegger, anxiety discloses the fundamental nature of human existence, and is a necessary, constitutive feature of authentic existence. The question then arises: how can anxiety be debilitating and pathological on the one hand, yet be definitive of human existence, revelatory, and constitutive of living authentically on the other? We might think that perhaps the term is being used to capture two, completely unrelated phenomena. While the DSM characterises the experience of anxiety as a kind of extreme concern or worry about things in one's life, for Heidegger anxiety seems to capture the opposite experience, as all one's dealings with the world are suddenly 'of no consequence' and 'the world has the character of completely lacking significance' (*Being and Time* H186). This paper will seek to show how the two uses of the term are not in fact distinct, and will suggest how anxiety, while potentially being debilitating, can nonetheless be important and transformative.

- ***Phenomenological approaches to mental illness across cultures: A case for Iranian dysphoria*** **by Moujan Mirdamadi:**

Cross-cultural studies of illness often assume that the diseases under study are grounded in biological and/or psychobiological processes, and are thus universal. Such a view, however, overlooks the fact that the phenomenological appearances of illnesses are shaped by culture (Good & Good 1982). Observing the cultural, and thus the phenomenological differences of illnesses prove to be especially important in studying mental illness across cultures. Such studies make it clear that the classifications and criteria for identifying and diagnosing mental illness as used in the Western countries, are not always readily applicable to countries with different cultural dynamics.

In this paper, focusing on the cultural and social make up of Iran, I aim to show some of such problems in conducting a cross-cultural study of depression. As a country where sadness and dysphoria are valued and even encouraged, there is a fuzzy boundary between what is considered a normal, general form of sadness, and more pathological affective disorders. In addition to arguing for a culture-centred study of depression, I will show how the knowledge of culture can inform a phenomenological study of depression, through a comparison of the phenomenology of depression in the UK and in Iran. One of the most striking differences between the experiences of depression in Iran and the UK is the role of the individual in illness: whereas in the UK the experience is more person-centred, similar experiences in Iran tend to be reliant on the social and interpersonal relationship with others. It is differences like this, which despite shaping the overall experiences of depression, tend to get overlooked in cross-cultural studies with the assumption of universality of causes and appearances of depression.

- ***The Necessity of Oblivion: Schopenhauer and Nietzsche on The Madness of Normality and the Normality of Madness*** **by Paul Stephan**

One of the core ideas of Nietzsche's philosophy, developed from his earliest to his last writings, is without any doubt that phenomena such as madness, which are suppressed by both rationalist philosophy and modern society, possess an intrinsic value that should be reconsidered in the context of a global 're-evaluation of values'. To be precise, according to Nietzsche madness lies at the bottom of any human culture, and thus its rationalist-modern suppression is not merely bad but it is dangerous as it jeopardises the existence of human culture as such and could lead to a nihilist dystopia.
A rarely noticed passage in Schopenhauer's The World as Will and Representation (§ 36) helps to get a better understanding of Nietzsche's apology of madness and to situate it within his overall philosophy. In this interesting paragraph, Schopenhauer develops a brief notion of madness that ingeniously anticipates the core idea of Freud's psychoanalysis: Madness is for him essentially a failure of memory which is caused by painful experiences in the past. In order to forget them, we have to replace these memories by others – and thus we become mad. Accordingly, madness serves for him

as an exemplary example how our intellect is always mastered by our will. Between normal memory and madness there is no difference in principle, but rather only one of degree.
Nietzsche radicalises this thought: On the one hand, he stresses more insistently than Schopenhauer the rationality of madness and the madness of rationality; on the other hand, he transforms the descriptive character of Schopenhauer's reflections into an apology, even praise of madness (and, accordingly, of the art of drama, which Schopenhauer too associated with madness, and of oblivion in general).
What we should learn from both thinkers is that madness should be seen not as something completely different from our normal, rational experience, but as an essential feature of human existence as such. This opens up a space for an actual dialogue between 'the mad(wo)man' and 'the normal' that seems to be as silenced in modern psychiatry and psychology today as ever. Especially Nietzsche highlights the prize modern culture has to pay for excluding the mad: It forgets about the conditions of possibility of its own existence and thus becomes possibly madder than the mad(wo)men.

- ***Mad Problems: A Critique of Mere Difference Views in Psychiatric Disabilities Rights Groups*** **by Samantha Hirshland:**

The Americans With Disabilities Act defines a person with a disability as a "person who has a physical or mental impairment that substantially limits one or more major life activity." However, many disability rights activists argue that this "limitation" is 1 due to society's treatment of people with disabilities, not the conditions themselves. Elizabeth Barnes calls this idea the "mere difference" view, referring to the idea that disability is "merely" a normal aspect of human diversity and that it does not necessarily make a person worse off on its own. In contrast, the "bad difference" view holds that disability is inherently bad for a person.
Although Barnes only discusses the mere difference view for physical disabilities, disability rights groups focused on psychiatric disorders, including the mad pride and neurodiversity movements, make similar arguments. In this paper, I discuss some of the implications of the mere difference view of psychiatric disorders. I argue that, while it may be accurate for some milder conditions, the mere difference view would be harmful to those with the most severe psychiatric disorders. The discussion proceeds as follows.
I first discuss examples of psychiatric conditions for which the mere difference view of disability is helpful and accurate, and I explain what differentiates these particular conditions from others where this model is inaccurate and unhelpful. I draw the line between mere difference and bad difference conditions where, if one were to imagine society was fully accepting of the condition, the condition would still cause pain. Although there are some conditions for which this distinction is hard to identify, I argue that this difficulty does not therefore mean all psychiatric disorders are mere difference or that psychiatric disorders do not exist.
Second, I connect the mere difference view to the mad pride and neurodiversity movements. After noting some of these movements' strengths such as their activism with regards to patient self-determination, I argue that their central weakness is their tendency to equate the fact that it is difficult to accurately diagnose psychiatric conditions with the idea that psychiatry as a whole is intrinsically flawed. I provide examples of where some of the weaknesses of these movements come from a mere difference view, and I argue that the good the movements have done will not be erased by a bad difference view.
Finally, I discuss possible issues that would arise for those with severe psychiatric disorders if more people were to adopt a mere difference view of all psychiatric disorders. Denying that any psychiatric disorder causes inherent suffering makes it more difficult to argue for broader access to psychiatric treatment and medication and impossible to argue for "cures" to these truly damaging disorders. A mere difference view is also simply inaccurate for some psychiatric disorders. For instance, for major depressive disorder, suffering is an inherent feature of the condition. Arguing that a person is not necessarily made worse off because of an inherently painful condition is misguided.

- ***Schizophrenia, Loss of Grip and Delusional Stabilization*** **by Philip D Kupferschmidt:**

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Is delusion the mind's attempt at solving a much deeper problem? As our understanding of psychosis changes, our understanding of the 'problem' to which delusion 'responds' also changes. But this approach to answering the question is flawed. The question is not 'does delusion have a purpose', but 'how does it fit into the subject's cognition?' Instead of 'how does delusion form', 'what *else* can delusion do?' I take this latter approach, exploring the implications of the ipseity-disturbance model of schizophrenia.

The ipseity-disturbance model, developed by Louis A Sass and Josef Parnas, is a phenomenological account of the origin and development of schizophrenia. They offer a comprehensive model of schizophrenic cognition, in cooperation with clinicians, cognitive scientists and phenomenologists at the Center for Subjectivity Research, in Copenhagen. In the ipseity-disturbance model, delusion formation is a particular cognitive response by which the subject thematizes subpsychotic experiential anomalies. Delusion originates as a cognitive response to an experienced disturbance. However, I find that the initial delusion-formation is only the beginning of a delusion's potential efficacy for the subject.

Ipseity-disturbance entails a destabilization of the self-to-world structure of cognition. When this most fundamental structure is disturbed, cognition turns back upon itself in structured, patterned ways. Processes following these patterns and structures produce symptoms.

In particular, I focus on the threat posed to cognition by something that they call 'loss of grip on the world'. The subject is caught in a perspectival flux from which s/he has access to the things of the world, but cannot maintain a fixed perspective. We find this 'loss of grip' most clearly expressed in formal thought disorder. Understood in terms of grip-loss, disorganization symptoms represent perhaps the most radical threat to the cohesion of the patient's cognition. Though delusion poses some ongoing threat to cognition, that threat is minor in comparison. Already a sign of grip-loss, disorganized speech can even weaken the subject's world-grip further. This realization gives a new angle from which to examine the speech of delusional, panicked crisis patients.

For case study, I examine passages from Elyn Saks' award-winning memoir, '*The Center Cannot Hold*.' I find there grounds to suggest that when this subject is caught in her delusions, this involves a partially-mediated perspectival flux. The subject may be caught in her delusions because this delusional perspective is the only perspective that remains intact. When her speech worsens her grip-loss, Saks' mind turns to the delusional perspective in such a manner as to slow down the perspectival flux. This is made possible by the unique experiential, cognitive status of delusion, and not by some hypothesized capacity. When subjects are in moments of great crisis, the delusion may actually be all that stands between this mediated flux and a total dissolution of perspectival thought. In short, delusion may be a solution to an entirely new problem, one distinct from that to which it first responded.