Madness as Dysfunction and as Strategy

Justin Garson
Department of Philosophy
Hunter College – CUNY
jgarson@hunter.cuny.edu

Note: These are rough, preliminary notes for a longer project. I'd love any feedback at this early stage.

1. Introduction

I wish to identify two intellectual frameworks, "paradigms" (as in Kuhn), or "epistemes" (as in Foucault), that have governed research and treatment in American psychiatry in the twentieth century, *madness-as-strategy* and *madness-as-dysfunction*. To put these on a rough and somewhat artificial timeline, the first, madness-as-strategy, dominated American psychiatry from the turn of the century to the early 1970s; the second dominated American psychiatry from the early 1970s until today, though they have always coexisted. I think there are specific social and historical factors that explain the transition.

The first approach, madness-as-strategy, views psychiatric problems as unconscious strategies that the person is deploying to achieve some (perhaps unconscious) end. From this stance, psychiatric problems, such as anxiety, depression, or even the delusions and hallucinations associated with schizophrenia, have a goal-directed or teleological dimension. The purpose of the psychiatric researcher is, as Harry Stack Sullivan put it, to "understand what the patient is trying to do." The second, madness-as-dysfunction, views psychiatric problems in terms of the breakdown, failure, or dysfunction, of a naturally occurring system, whether that failure is biological or psychological. In a sense, this paradigm sees mental disorders as involving precisely the absence or breakdown of teleology. The purpose of the researcher is to locate the source of the failure and to fix the system.

After elaborating these two different perspectives, I'll indicate at least four benefits of recognizing the existence of these perspectives, for history, psychiatry, and philosophy. The first benefit has to do with historiography. It gives us a better framework, or lens, for reconstructing the major movements of twentieth century American psychiatry. Everybody agrees that some major transition took place in American psychiatry in the 1970s. Sometimes this is described in terms of the ascent of the "medical model;" sometimes it is described as a "second biological revolution." I think a better way to understand this transition is in terms of a switch from the madness-as-strategy paradigm to the madness-as-dysfunction paradigm. My sense is that the idea of the "medical model" is too amorphous to do much analytical work; also, I suspect that the changes wrought in the 1970s crosscut the biological/non-biological distinction. There's nothing specifically "biological" about the idea that mental disorders stem from an inner dysfunction. There are, for example, cognitive or psychological dysfunctions. What

happened in the 1970s was that researchers began leaning very heavily on the idea of dysfunction to make sense of mental disorders.

A second benefit has to do with actual research and treatment decisions. I think there are some research programs today – though still in the minority – that are both promising and scientifically rigorous, and that are based on the idea that mental disorders have some strategic or adaptive value. Some of these are rooted in evolutionary psychology (e.g., the idea that depression is an adaptation for dealing with interpersonal conflict), some are rooted in developmental psychology (e.g., that anxiety represents an outcome of developmental plasticity and that it is an adaptive response to a hostile early environment), and some are rooted in cognitive neuroscience (e.g., the idea that the delusions of schizophrenia may have some adaptive value in helping an individual adjust to perceptual abnormities). I think it's useful to see all of these diverse projects as embodying a core vision (madness-as-strategy) and as representing a resurrection of a way of thinking that was common in psychiatry prior to the 1970s.

A third benefit has to do with the philosophy of psychiatry, and in particular, the vexing question of the *concept* of mental disorders. Since the 1970s, some philosophers and philosophically-minded psychiatrists have tried to explicate the very idea of mental disorder in terms of a breakdown or failure of function (e.g., Boorse 1977; Klein 1978; Wakefield 1991; Nesse 2007), and these approaches are quite popular though controversial. My sense is that once we recognize the existence of two quite distinct, and somewhat competing, approaches to psychiatry, we'll see that these attempts to define mental disorder in terms of (inner or biological) dysfunction represents an extremely narrow, and limiting, way of thinking about what disorders are. These definitions do not represent a timeless truth about mental disorders; instead, they simply echo or reinforce a certain paradigm that became common in the 1970s for specific social and historical reasons.

A fourth potential benefit has to do with the possibility of lessening stigma associated with mental illness. The idea, simply put, is this: if I see your words and actions as nothing more than the byproduct of a disordered brain then I tend to devalue them or dismiss them. As psychologist Richard Bentall puts the point, "… research shows that an exclusively biological approach tends to increase the stigma associated with mental illness. The more that ordinary people think of mental illness as a genetically determined brain disease, and the less they recognise it to be a reaction to unfortunate circumstances, the more they shun psychiatric patients. An exclusively biological approach makes it all too easy to believe that human beings fall into two subspecies: the mentally well and the mentally ill."[1] I suspect that this idea of madness-as-strategy gives us a way of escaping from the almost irresistible tendency to equate mental disorder and inner dysfunction.

[1] https://www.theguardian.com/commentisfree/2016/feb/26/mental-illness-misery-childhood-traumas

2. Madness as Strategy[2]

Since the 1970s, clinical psychologists have lamented the degree to which professional psychiatrists in the United States have "medicalized" everyday problems. Historians routinely describe the complex transitions that took place in American psychiatry in the 1970s in terms of the imposition of the "medical model." We all recognize that the third edition of the DSM, the DSM-III of 1980, signaled a fundamental change in the way that psychiatry is practiced in the United States, and that the change had something to do with "medicalization." Sometimes these changes are also described in terms of a "second biological revolution." So, what exactly took place in psychiatry in the 1970s that these phrases are supposed to denote?

I'm going to suggest the following account of the transition that American psychiatry passed through in the 1970s. I believe that what was most distinctive about this transition was that American psychiatrists went from seeing mental disorders as (generally unconscious) *strategies* to seeing disorders as *dysfunctions*. In other words, prior to the 1970s, many psychiatrists considered mental disorders to represent, at base, *various strategies that people deploy, unconsciously, to cope with unpleasant situations*. Mental disorders possessed a teleological dimension. They were "for" something. The characteristic symptoms of mental disorders represented the working out of various strategies to resolve, or deflect, or live with, unpleasant situations. There was neither an implication that these strategies were consciously selected, nor that they were successful. In fact, they were typically unconscious and potentially quite harmful. As the American psychoanalyst Harry Stack Sullivan (1962, 8) put it, the clinician's job reduced to the following: "We must understand what the patient is trying to do." A few examples will suffice to demonstrate the point.

> (i) For Freud, dreams, slips of the tongue, and neurotic symptoms all represented distorted fulfillments of repressed desires. Consider Freud's account, in 1917, of a young woman's protracted and compulsive bedtime routine, which involved arranging her pillows in a diamond-like shape (Freud 1966, 327-333). In Freud's view, her ritual was nothing more than a symbolic fulfillment of her wish to usurp her mother's place. The distortion, moreover, served the goal of preventing herself from becoming aware of the true nature of this desire. So, compulsions played various functions in her psychological economy. They represented the working out of a certain strategy. They were goal-driven and goal-directed.
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> (ii) Harry Stack Sullivan was largely responsible, in the 1920s and 1930s, for the attempt to carry Freudian insights from the clinic to the asylum, and to use psychoanalysis to illuminate, and treat, schizophrenia. Sullivan was well known for emphasizing the social dynamics of schizophrenia, that is, the extent to which

[2] Parts of this are taken directly from Garson, J. (2016) "The Hiddenness of Psychological Symptom Amplification: Some Historical Observations," in Moseley, D. D., and Gala, G. (Eds.), *Philosophy and Psychiatry: Problems, Intersections and New Perspectives* (New York: Routledge), pp. 29-35.

schizophrenia was an interpersonal disease. He viewed schizophrenia within a teleological framework. In his view, catatonic-type schizophrenia represented a regression to an earlier stage of psychological development. The function of this regression was to enable the patient to better incorporate distressing life experiences into his or her personal narrative (Sullivan 1962, 20).

(iii) In the 1930s and afterwards, figures such as Wilhelm Reich (1972) and Anna Freud (1946) developed psychoanalytic theory substantially (before Reich's expulsion from the International Psychoanalytic Society) through the study of human character traits. A crucial idea here was that personality types, mannerisms, or even bodily postures could represent mechanisms for defending the ego against id impulses as well as for "interfacing" with other people. Reich referred to these mechanisms as "character armor" and summarized his view concisely: "…the neurotic character traits as a whole prove to be a compact *defense mechanism* against our therapeutic efforts, and when we trace the origin of this character "armor" analytically, we see that it also has a definite economic function (48)."

(iv) In the 1950s, one of the most well-known theories of schizophrenia was the "double-bind" theory (Bateson et al. 1956). In this view, symptoms of schizophrenia such as delusions and disorganized thought represented mechanisms that people used for the purpose of resolving what the psychologist Gregory Bateson and his colleagues called a "double-bind" situation. In their view, as a child the patient was repeatedly confronted with a kind of "lose-lose" situation (typically imposed by the mother) in which any coherent response would be penalized, and which forced the patient to adopt more radical solutions, such as delusions and incoherent speech. (Though nobody wishes to return to the stigmatizing idea of the "schizophrenogenic" mother whose terrible nurturing practices drive her kids crazy.)

(v) The American Psychiatric Association (APA), in the first edition of the DSM, canonized this view that mental disorders of different stripes could be understood as coping mechanisms. They were seen as goal-driven and goal-directed. In that manual, the APA recognized three major types of non-organic mental disorders: psychotic, psychoneurotic, and personality disorders. Crucially, it depicted *each type* as representing a different sort of strategy for resolving inner psychological conflicts. The psychotic reactions are those in which, "the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism, and withdrawal from reality…" (APA 1952, 12). Psychoneurotic reactions are defined in terms of the various mechanisms that the patient uses to combat anxiety, such as depression, phobias, and compulsions (ibid.). The personality disorders take place when the patient "utilizes primarily a pattern of action or behavior in its adjustment struggle…" (Ibid., 13).

Not everyone viewed mental disorders as strategies. For example, Emil Kraepelin, that pillar of the "medical model," believed that many mental disorders could be understood

as diseases of the brain or nervous system or as hereditary conditions. The idea that they represented strategies for coping with psychological conflicts was almost absent from his viewpoint. Almost, but not entirely! Kraepelin himself recognized that certain symptoms might represent the working out of a strategy deployed by the patient. For example, in his discussion of acquired neurasthenia, he tells us that chronic invalidity can, in some cases, represent a strategy for perpetuating the sick role and acquiring its associated benefits. In the most extreme cases, he tells us, "the patients tend to become chronic invalids of a most distressing type…They betake themselves to the seclusion of a charitable institution with its freedom from annoyances…The increasing demand for sympathy leads to prevarications and to various assumed contortions, in order to assure the physicians or friends that they are in critical condition" (1912, 152-153).

3. Madness as Dysfunction

All this changed in the 1970s, with the process that led to the publication of the DSM-III. The story has been told elsewhere; I will summarize it very briefly here (see Garson 2015, Chapter 8, and references therein). The APA was in the midst of several conflicts. Within the ranks of the APA itself, biologically- and behaviorally-oriented psychiatrists were in conflict with psychodynamically-oriented psychiatrists (as well as with clinical psychologists associated with the American *Psychological* Association). The APA was also engaged in an ideological battle with the so-called "antipsychiatry" movement, which saw mental disorders as mere "problems in living," or as social deviance. As a strategy for responding to their critics, powerful individuals within the APA, notably Robert Spitzer and Donald Klein, worked tirelessly to promote a certain framework for thinking about mental disorders, namely, the perspective of disorder-as-dysfunction. This perspective was canonized in the DSM-III as part of a working definition of "mental disorder" itself (APA 1980, 6). Psychiatrists and mental health advocates repeatedly emphasize the analogy between mental and other non-mental medical disorders, for example, by calling schizophrenia the "cancer of mental illnesses."[3]

One of the consequences of the ready adoption of this viewpoint was that what I'm referring to as this teleological framework for thinking about psychiatric problems was effectively abolished. Psychiatric symptoms were simply the result of various sorts of "behavioral, psychological, or biological dysfunction[s]" (APA 1980, 6). Just as there's no sense in which cancer or diabetes represent the "working out of a strategy" on the part of the patient for accomplishing some unconscious goal, neither do mental disorders (which are, after all, merely physical disorders that manifest in a special way in the mind). This framework, for better or worse, persists to the present day. For example, recently, some psychiatric researchers have been advocating for a transition from the DSM system of classification to a new system of classification, the Research Domain Criteria (RDoC), promulgated by the National Institutes of Mental Health (NIMH). Advocates of RDoC, however, still insist, as loudly as ever, that mental disorders boil down to inner dysfunctions (Insel et al. 2010, 748).

[3] http://www.loc.gov/loc/brain/emotion/Weinberg.html, accessed October 2, 2016.

Here are two examples of the way in which American psychiatry, since the 1970s, has been oriented toward the search for dysfunctions underlying mental disorders:

> (i) The publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the DSM-III, represented a turning point for American psychiatry. Relative to the slim DSM-II, this was a massive classification that attempted to provide detailed, "atheoretical" (APA 1980, 6) criteria for diagnosing various mental disorders. Although the DSM-III did not attempt to provide a rigorous definition of "mental disorder," it did provide a working characterization: "In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological *dysfunction*, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between the individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.)" (APA 1980, 6; emphasis mine)
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> (ii) Today, in the aftermath of the publication of the DSM-5, some psychiatric researchers are shifting to a novel system of classification, the National Institute of Mental Health's (NIMH) *Research Domain Criteria* (RDoC). RDoC describes a new way of classifying mental disorders by the specific functional capacities ("domains," which are subdivided into "constructs") that are disrupted, such as attention, memory, and attachment, rather than groups of outward symptoms. Nonetheless, even in this newer system, mental disorders are thought of as resulting from dysfunctions in one or more of these various domains or constructs. For example, as one of the leaders of the RDoC project and the former head of NIMH put it, "RDoC classification rests on three assumptions. First, the RDoC framework conceptualizes mental illnesses as brain disorders. In contrast to neurological disorders with identifiable lesions, mental disorders can be addressed as disorders of brain circuits" (Insel et al. 2010, 749; also see Sanislow et al. 2010)

RDoC does nothing to lead us away from a dysfunction model of mental illness; rather, it entrenches that model.

4. A Resurrection of the Madness-as-Strategy Model?

Since the turn of the century, a handful of research projects have emerged that explicitly consider some mental disorders to have adaptive or functional significance, *perhaps in addition* to involving inner dysfunctions. They are thought of, in *some limited respects*, as embodying (adaptive, coping, or defensive) strategies. Thus they hark back to the pre-1970s paradigm for thinking about mental illness. But there is a crucial difference. While prior to 1970s, the madness-as-strategy paradigm was closely associated with

psychoanalysis, these contemporary approaches are anchored firmly in the biological sciences: evolutionary biology, developmental biology, and cognitive neuroscience.

Three examples will suffice to illustrate the point:

(i) Some psychiatrists argue that various mental disorders, including anxiety disorders, may illustrate developmental plasticity. That is, they represent "switches," adaptive responses designed to help the individual better cope with future stressors. Crudely put, suppose an infant or young child grows up in an environment with many (perceived) dangers. There is fairly solid research to suggest that such individuals may have a higher susceptibility to anxiety disorders as adults (Seckl 2008; Glover 2011; Gluckman et al 2009, Chapter 9). Here is a somewhat speculative hypothesis: what if the susceptibility to anxiety disorders represents an adaptive response to a formative context perceived as hostile? The underlying idea is that anxious people are more vigilant to potential threats than people who are not anxious. If that is correct, then anxiety disorders are not dysfunctional – or not entirely so – but have a functional or adaptive significance. This does not mean that anxiety is "good for us" or that it always has these associated benefits. It just means that when we try to figure out what anxiety is or why it persists, it might be beneficial to regard it as embodying a "strategy" for dealing with potentially hostile environments. Glover (2011) also extends this way of thinking to ADHD and conduct disorder.

(ii) Another example of a research project that centers around the idea that mental disorders may have functional or adaptive significance – that is, that they represent evolved "strategies" for enhancing fitness – comes from evolutionary psychology, and particularly that wing known as "evolutionary psychiatry" (e.g., Stevens and Price 2000; also see McGuire and Troisi 1996; Nesse and Williams 1994; Geary and Bjorklund 2000). Here, mental disorders are often seen as *adaptations*. I don't mean that they are fitness-enhancing today, but that they evolved by natural selection because of some benefit they conferred on our ancestors, and particularly those in the Pleistocene era (from about 200,000 to 10,000 years ago). Disorders such as depression, anxiety, and psychopathy, have been studied from this angle. Again, the point isn't that disorders are good for us. Also, the point isn't to embrace every aspect of evolutionary psychology, which has been criticized as consisting of little more than "just-so stories" about our distant ancestors (e.g., Lewontin 1998). The point is that if we stubbornly cling to the idea that mental disorders are mere "brain dysfunctions," we'll fail to understand what they are and hence fail to treat them appropriately.

(iii) A final example comes from cognitive neuroscience of schizophrenia, and particularly, of delusions. One fascinating theory – and as yet, it is no

> more than a theory – holds that the delusions associated with some types of schizophrenia constitute an *adaptive response to certain low-level perceptual abnormalities.* (Uhlhaas and Mishara 2007; Mishara and Corlett 2009; see Bortolotti 2016 for recent philosophical discussion). The idea, simply put, is that schizophrenia is ultimately caused by some kind of perceptual dysfunction (though different theorists disagree about its precise nature). These perceptual abnormalities disrupt day-to-day functioning. The subject then comes up with a system of delusions that helps to both *explain* the perceptual abnormalities and thereby *allow* a semblance of normal functioning.

The point is that, when we allow ourselves to even *pose* the question of whether some mental disorders have adaptive or functional significance – whether they represent, in my parlance, "strategies" rather than "dysfunctions," we create new approaches to research, treatment, and classification. These approaches are difficult to see if we are stuck in the habit – as encouraged by the authors of the DSM-V and the proponents of RDoC – of thinking of mental disorders as cognitive or biological dysfunctions and nothing more.

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