FOUR

Unsettling impairment: mental health and the social model of disability

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Introduction

This chapter advances an account of the social model of disability (SMD) that questions impairment and the application of the model in the areas of mental health and distress. It does so by critically examining the relationship between *impairment* and the *social,* which, in a simplistic application of the social model, is often taken as unproblematic. The concerns voiced here cannot be resolved within the chapter, nor without the involvement of a mad and disabled constituency. That said, my purpose is to advance a critique that unsettles notions of impairment in both psy science (this is the term used throughout this chapter to denote the psychiatric and clinical psychological sciences) *and* the social model of disability. Whether or not this critique suggests the necessity of a different iteration of the social model for mental health remains to be seen, and it should not be read as a criticism of the achievements made for disabled people through the application of the social model so far. Rather, this chapter aims to crystallise what I believe is a crucial tension in advancing the rights of people with mental health problems who identify as disabled. This tension is that if medical and psy sciences lack the evidence to supply a cogent account of impairment in mental health, then the social model of disability, which relies equally on notions of impairment, is destabilised. The dilemma is whether the social model can, or should, overlook this unsettled impairment.

The shifting ground of impairment and disability.

The social model of disability is ensconced in disability and equality legislation, which considers long-standing psychosocial distress to be

a disability while relying upon psychiatric diagnoses and classification. The social model is, moreover, widely acknowledged as the preferred way for disabled people to have their needs met and to articulate their experience. While the social model appears to have been embraced, legislation, policy and practice remain clinical, using the language of the helping professions. Take for example the following passage from an article in the British Psychological Society's (BPS) periodical *The Psychologist*: '*Most of the time we think* about *clinical conditions*, such as autism or ADHD or schizophrenia or depression, individually. Yet *in reality* it is *extremely common* for people to show more than one condition together' (Ronald, 2014, 164, my emphasis). This article was written less than a year after the BPS published its position on the then new diagnostic manual, DSM5, stating that it would recommend psychologists not to use DSM5 in clinical practice because it lacks validity and pathologises everyday experience (BPS, 2013). Yet Ronald goes on to celebrate aspects of diagnostic changes in the new DSM5. When the quote above is read with my emphasis we see an invitation to join the author's assertion and professional positioning (we), that there are accepted entities for study and treatment (clinical conditions), and that there is both an epistemological and an ontological certainty (in reality). Furthermore, we are invited to accept that clinical diagnostics arriving at a singular diagnosis are partially correct, and those that arrive at an integrated diagnosis offer a different scale of accuracy. I suggest that Ronald's quote exemplifies the current situation in mental health and the social model of disability. That is, that despite the demands of law and policy, and the disciplinary objections to unscientific diagnostics, it remains permissible for disciplines to continue to objectify disabled people. Snyder and Mitchell (2006) point out that this can even be a problem within service user-led research.

A critical, historical account of disability highlights the intersection of ideas and practices that made possible the 'disabled person'. Ideas about impairment are crucial to this. First, the growing acceptability of pathological science late in the seventeenth century enabled natural scientists to compare organs and model functions noting those that depart from the regularity of bodily repetition (Foucault, 2010). Second, in the early 1800s, with greater urban populations, there is the advent of demographics, government figures in Europe and the study of statistics (Davis, 1995). Given the imperialist projects of the time, and the preoccupation with ancestry, primitivism and subnormality, there are the conditions necessary and amenable for a science of eugenics. If industrialisation relies on a capable and efficient workforce within a European context of white Christian, masculine superiority, it raises

the question of whether the body can become increasingly perfected and efficient (Foucault, 1991). In the nineteenth century there is the somewhat arbitrary separation of 'retarded development' from 'madness' on the basis of presumed aetiology and course (Foucault, 2008). These intellectual and material conditions make it possible for a segment of the population to be designated as undesirable and unproductive. The segregation of the unproductive disabled (alongside the idle and criminal), became a lesson to those that do not work. The potential for removing them, both from the factory and from the gene pool, became more apparent in post-Darwinian discourse. With economic activity and productivity linked increasingly to upstanding morality, aspiration and material conditions, a self-serving rationale is developed for both identifying non-normative forms of being and the necessity of the disciplines that survey and ameliorate their expression.

Conceptions and contestations of 'impairment' within the disability field.

Given this history, impairment is usually defined as a deficit, lack, dysfunction or abnormality that negatively reduces or changes function. The assessment of impairment is usually arrived at through clinical judgement on the basis of statistical infrequency or professional consensus, or both together. The first notes that a given difference or phenomena is infrequent when measured, and so it is abnormal by dint of its relative rarity. Such measurement is presumed to be reliable and valid. The second (professional consensus), can be operated in a variety of ways and merely requires enough agreement by those people exercising sufficient power to decide whether what is being measured or assessed is impaired. For instance, depending on where the assessment is made, HIV status could be either statistically common or rare but, either way, it is viewed as a sufficient health state to be impairment. In contrast, sexual minorities have, in professional and political terms, historically been viewed as ill and pathological. This was simply a (prejudiced) consensus view and did not require a coherent account of illness or impairment.

There is an implied, and often accepted, constancy to impairment, based on the assumption that impairment is medically describable and relatively stable. Impairment is often seen as an *acultural* and *atheoretical* classification that merely describes a *true* physical or psychological state. This *neutral* notion of impairment has been questioned and challenged (Tremain, 2006; Penson, 2011). If medicine and psy science represent their knowledge as neutral, then what they point out during diagnosis

is merely the 'fact' of the abnormality. However, as Foucault suggests, the belief 'that the body obeys the exclusive laws of physiology and that it escapes the influence of history…is false' (Foucault, 1971, 87). Thus, what appears initially to be an unproblematic assessment of physical or psychological difference is actually embedded in social experience. Moreover, it becomes subject to disciplinary discourses and practices. The perceived stability of impairment is also in question given that only 15 per cent of disabled people are born with their impairment (Davis, 1995). Among the rest there is great variation in how impairment is acquired, to what extent, under what circumstances and to what effect. This notion of impairment (assumed, distinguishable and constant) is seen as underpinning the variable social experience that follows. According to the social model of disability, it is the combination of impairment and social response that demarcates 'disability'.

The current application of the social model could be accused of failing to re-integrate the impairment and the social after making the initial separation. In actuality, impairment is always in an environment, is socially described in clinical knowledge in advance of its expression, and impairment is always socially located.

If impairment is contested there are two implications. First, the presumed stability, clinical neutrality and fixity of impairment as something knowable and describable that sits anterior to the disabled experience, is removed. Second, and by extension, a *double-social model of disability* is implied. By this I mean that, if the neutrality of impairment is placed back within discourse, there is no component of the social model that is not social, and so impairment and disability both become subject to social, disciplinary and cultural forces. In the initial separation of impairment and the social in the social model, construction and meaning was seen as only located in the social response. In a *double-social model of disability* both the impairment and the social response are constructed. Impairment is equally as socially constituted as is the social response; it is not a natural, essential category outside of human designation.

Impairment in mental health and psy science

The state or identity of *disabled* relies on the assessment of an underpinning impairment, of sufficient presence to disrupt a range of normative expectations. Psy science holds the view that states of madness, mental illness and pathological distress carry with them an underlying set of deficits that constitutes impairment.

Yet there are two main problems with this. First, that there remains little clear evidence of underlying pathology in any of the functional mental health diagnoses; and second, it is not clear what constitutes a deficit rather than a variation, and a presumed deficit may not be the impairment but rather a sign of a further underlying difference. This is not to doubt the existence of a biology of distress, but to question whether distress and unusual experiences are illnesses and diseases. As we have seen, the concept of impairment is open to question – even in physical disability where it is arguably more amenable to description. If this challenge is accepted then the categorisation of psychiatric 'impairments' must be even more contestable. This offers a conundrum for the social model of disability in mental health and distress. If it is essential to the social model for the split between impairment and disability to be made, what is the impairment that we can reliably call upon in mental health and distress? The following section identifies the problem with other ways of defining impairment which might be proposed to try and get around this difficulty.

Problems with others ways of defining impairment.

One might propose that being prevented from full participation in society, or not being able to respond to life's normative demands, because of social exclusion and oppression, is sufficient for a disabled identity. However, this would include other people, such as asylum seekers, who are excluded and living on fractions of a survivable income, but without impairment. Similarly, we might suggest that certain bodies are excluded and disabled because they differ from those in mainstream, normative society. However, physical difference alone is insufficient to be judged as impairment even where that difference is characterised as inferior. People from ethnic minority groups are excluded on the basis of such physical differences when white, European benchmarks of skin colour are used (Davis, 1995) against a historical backdrop of eugenics, racist ideology and colonialism. What is the threshold for differences to become impairments? What about health differences? Or risk of ill-health? Health differentials can be seen in multifactorial risk models of aetiology. These include familial histories of heart disease and cancer. Could we see negative health potentialities as impairments? This is unlikely to be popular as a means of assessing disability because it would include all poor people in a population, since poverty is a determinant of poor physical and mental health. Yet, while some ill-health potentialities have no disability status (poverty), others do. For instance, dietary-controlled diabetes, multiple sclerosis

and cancer in remission, and a non-symptomatic HIV positive status, can all constitute a disabled status even with no evident impairment. In these cases, it is the social responses and psychological adjustment to the health status that are problematic.

These examples show that while the social model of disability differentiates impairment from the social response, in practice, impairment is socially inscribed; impairment *is* a social response. Difference and variety are natural occurrences, but how we then note them and classify them is not. To arrive at the knowledge of being impaired, either by one's own or another's definition, is to have judged the social response as viable – you come to know your own difference. An exemplar of this is found in *The Reason I Jump* (Higashida, 2013) which is an autobiographical account of autism. Higashida writes in his preface,

> When I was small, I didn't even know that I was a kid with special needs. How did I find out? By other people telling me that I was different from everyone else, and that this was a problem. True enough. It was hard for me to act like a normal person… (Higashida, 2013, 15)

Higashida confirms that, for him, impairment was not an originary moment but rather it is the social response towards him which in turn confirms his presumed impairment. This begins his knowledge of difference.

Distress, norms and the social model of disability

The notion of impairment is only plausible on the grounds that there is a normal body and mind, visible, measurable and desirable, against which non-normative bodies and minds can be benchmarked. While some people do have bodies and minds at variance with others, this remains a somewhat arbitrary matter of degree. How far does one need to deviate from a culturally formulated norm to be constituted disabled? Currently, this problem is resolved primarily through diagnosis.

In mental health, this brings particular complexities. The World Health Organization (WHO) predicts that by 2030 depression will rank as 'the leading cause of disease burden globally' (WHO, 2011a, 1). Remove the clinical language and this evokes a picture of many, if not most, people being persistently miserable by 2030, with psychiatry as our main response to this 'pandemic' (critiqued by Mills (2014). If we accept this proposition, we might ask a further question: if mental

health is a disability, and disability is a state that is beyond the norm, what are the implications for practice when the persistent states of misery (depression) and fear (anxiety), are so prevalent they become the new norm? What is the useful separation that can be sustained in the social model of disability or medicine when the disabled population is so expanded. How do we understand stigma and exclusion on the basis of attitudes to impairment if so many people are impaired? Perhaps this demands a shift in focus, to that of interrogating normality, not difference.

If my argument, that impairment and disability are fluid, that *both* are socially construed, is accepted, we then entertain the idea that there are fundamental flaws in the way that the 'activities of helping' are organised, not least of which is the problem of classification on which all else is predicated. In this scenario, the helping role is not redundant,

There are three implications for impairment that arise from the World Health Organisation prediction. The first is a system of classification that by its own assessment of scale seems over inclusive and without the means to corroborate a diagnosis (no blood test, scan or urinalysis). Those that seem to have the most to gain from this are disciplines that extend their influence and place more people under their 'necessary' purview, and increase 'market demand', for example, for the products of Big Pharma (Mills, 2014). Second, given World Health Organisation predictions, services would need to be so nuanced and responsive that the costs, burdens and adjustments would be of far too great a scale. The third implication relates to the cause of this increase. If, as predicted, the global south is to bear the brunt of the rise in depression by 2030, why is this happening? Is it a biological predisposition thus far unexpressed but which is accelerating? If so, how far is this from racist and eugenic propositions of the early twentieth century?

Linking the social model of disability, policy and practice

The social model of disability has become influential in health and social care policy and this can be critiqued on two levels. First, adopting it for mental health to inform legislation unintentionally imports unquestioned assumptions about impairment (such as the ones outlined thus far in this chapter). Second, there is an acceptance that systems of classification already in operation (here, psychiatry) are relevant, reliable and valid as the basis for assessing such impairment. Altered states associated with bipolarity and psychosis, and problematic mood states such as anxiety and depression, make the transition from psychiatric categories to legal categories of disability. This implies that, while

anxiety and depression are disabling (in clinical and policy terms), grief and anger are lagging behind. I think that this has two effects: the first is to suggest that some mood states rather than others have credibility as disabilities, and so should be privileged in their induction into the order of disability. The second is that psychiatric classification must be worthwhile because the mood states that it describes are disabilities; a self-perpetuating circularity. Thus, it appears, disciplines can 'sift' impairments.

Arguably, the social model of disability has colluded in the induction of people both into psychiatry (through deploying diagnostic labels) and into our legal/administrative systems (through employee assistance and welfare benefits). Medicine, through its own activity and that of other health professionals, is still the gatekeeper to assistance and adaptation; self-definition only gets one to the first gate. The limitations of the social model and some shrewd manoeuvring on the part of disciplinary interests (see Trueman, 2013, for an account of how the Royal College of Psychiatry used its position to skew its level of involvement in the amendment of the Mental Health Act), have resulted, I would argue, in this unacceptable status quo. This is not least because a model of activism has been co-opted and assimilated, rendering the disabled/mad dissident voice impotent. How does one find a voice, and talk back to the people who advocate one's own model of dissent (but who may then practice through the objectionable medical model)? Disciplines are trading on their status as helping professions that are scientifically validated and ethically rigorous, but the life outcomes for the disabled generally, and for people with mental health problems specifically, remain poor (Schizophrenia Commission, 2012) found people with this diagnosis lose on average 15 to 20 years of life compared to a non-clinical population). This is despite dominant narratives of recovery and optimism.

The social model of disability is driven by the intention to gain protections for the people concerned. However, there is a cost to accepting medicalised definitions of impairment and there appears to be no acceptable alternative way of defining impairment which is so loose that it would include substantial sections of the population. This is not a plea for greater exclusivity in who is (or isn't) awarded disabled status, but rather it raises the question of what psy science and medicine gain by their participation in the lives of people with mental health problems.

Conclusion

The absence of a discernible disease-based impairment – despite biological psychiatry's own claims of a biological basis for mental ill health – has not stopped distress and misery from being inducted in to the pantheon of disability. This cements the psy sciences as the 'impairment certifiers' and confirms the 'mad' and miserable in their status as disabled. Furthermore, the possibility that misery and madness are consequences of urbanisation, poverty and capitalism is denied; political responses are nullified, and dissent is typified as resulting from lack of insight or the marginal ramblings of academic malcontents. By engaging with normative, medical and psychological models, humans remove the possibility of viewing madness as a human variation and misery as a natural response to circumstance. Perhaps *the Mad* would prefer a position analogous to that adopted by Deaf communities, of being a linguistic minority and not disabled (Davis, 1995). Rather than being pathologised, segregated, subject to inhumane treatment and rehabilitation, through theories of sub-normality, *the* mad would then become a natural variation, a sub-culture with a changing membership, with degrees of participation.

It is not new for subjugated populations to be benchmarked unfavourably against a supposed neutral, racialised, gendered, able norm. All civil rights movements have had to contend with their members being construed as physically, psychologically or spiritually inferior. Perhaps mental health problems would be better articulated as neurodiversity, or post-traumatic growth, allowing for the arguments of social justice to be mounted without a commensurate acceptance of an underlying pathology or deficit; difference, without capitulation to inferiority or the abnormal. This would remove the concept of impairment from the social model of disability and replace it with one of difference that is variably maltreated and unaccepted. We could therefore alleviate distress through social and political means, without recourse to disease models that result in stigma and damaging treatments (this is part of what the social model aimed to achieve).

This critique of impairment is not easily resolvable through a new term or idea. Arguably, continuing to use a wrong notion because it is what we have, and has a certain tradition, is even more problematic. It is what Feyerabend (1975) refers to as the 'material force'*,* the political power of traditional thinking which limits what it is permissible to say and do within a given field. Rather than seeking to fit mental health and distress into the SMD, issues raised in this chapter might result in its transformation. If impairment itself is mutable perhaps, as

I have argued, a *double-social model* has explanatory power. In the first instance this double-social model might require a renewed vigour in questioning how disciplines operate models of impairment in practice. It might also question the implied normativity that seems to be a fiction for most people. Lastly, it might build bridges between groups of disability activists dissatisfied with the ways in which their difference and variation is only ever referred to in normative terms (such as 'function').

Despite these problems, the social model of disability has a productive history in the campaign for disabled civil rights. So, while the working out is done – and for so long as psychiatry is practiced (even in the absence of robust evidence), the social model retains an important place. The social model of disability does explain why disabled people have certain social experiences past the point of diagnosis. However, on-going scholarship and activism should be cognisant of the possible concession that advocates of the social model of disability in mental health might be making on the notion of impairment. The range of experiences falling within the reach of psychiatry continues to extend; whether that is advantageous to people in distress is questionable. However, there remains a paradox for activists and people with mental health problems alike. Currently, to forgo psychiatric diagnosis is to forgo the social recognition of impairment, and subsequently the conferment of a legitimised disability, along with the help that follows. This paradox has far-reaching implications for people who are struggling with mental health issues but do not accept notions of impairment and the psychiatrisation of their distress.