A Wide-Enough Range of 'Test Environments' for Psychiatric Disabilities

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Abstract

The medical and social model of disability is discussed and debated among researchers, scholars, activists, and people in general. It is common to hold a mixed view and believe that some disabled people suffer more from social obstacles and others more from medical problems inherent in their bodies or minds. Rachel Cooper discusses possible 'test environments', making explicit an idea which likely plays an implicit part in many disability discussions. We place or imagine placing the disabled person in a range of different environments. If there is a relevant test environment in which they do fine, their problem was societal/external; if there is not, it was medical/internal. Cooper admits that deciding on the appropriate range of test environments is an ethical and political question. In this chapter, I argue that we often ought to widen our scope when discussing psychiatric disabilities.

1. Medical and Social Theories

It is common to distinguish between medical and social *models* of disability. According to the medical model, disabled people are limited by their impaired bodies or minds. Ideally, disability should be cured through medical interventions (Anomaly, Gyngell, and Savulescu 2020). The social model sees disability as a social construct; people are disabled by the barriers and attitudes that exist in society. We should remove these barriers and make society more inclusive to enable everyone to participate fully (Tremain, 2017; Chapman, 2020). However, a model cannot strictly speaking be true or false; insofar as scholars, researchers, and activists attempt to present a *true* account of what, in fact, mostly hinders disabled people from living fulfilling lives, or what mostly causes disabled people to suffer, it makes more sense to talk of social and medical *theories* (Wasserman and Aas, 2022).

One might think of these models or theories as endpoints on a spectrum. Many people, including disabled people themselves, have a mixed view which lies somewhere in between (e.g., Vedder, 2005; Shakespeare, 2006). Moreover, the social and the medical aren't the

only games in town. One might speak of an analytical model, a relational model (Wilson, 2003), or even an economic model (Wolff, 2020, pp. 157–9). Still, much of the non-academic discussion focuses mostly on the medical, the social, and various intersections and mixes between the two, and this book chapter follows this example.

I believe there are important pro tanto reasons to accept disabled people's own explanations of their struggles and difficulties, whether they lean more towards the medical or social end of the spectrum. Only pro tanto, since it's clearly possible to be mistaken about one's own situation – as my own case, to be discussed later in this chapter, will show. Still, we need overriding reasons not to trust people's self-explanations; for this reason, and because 'psychiatrically disabled people' are such a big and diverse group, I will not argue that a social theory is true across the board.

I will, instead, argue for the weaker but nevertheless important claim that we tend to use a very narrow range of 'test environments' when considering whether someone's problems are mostly social or more medical in nature. If there's a tendency to overestimate the extent to which people's problems are medical, and underestimate the extent to which social factors make people struggle and suffer, any efforts to help psychiatrically disabled people and ease our burdens will be decidedly suboptimal.

2. The Concept of Test Environments

Rachel Cooper (2017) explicitly introduced the term 'test environment' in disability discourse, though I believe this concept often plays a role, at least implicitly, in many social-medical debates, whether it's given a name or not. Cooper argues that a person's condition might be considered an inherently neutral neurodivergence – rather than an inherently bad mental impairment – if there's 'some acceptable test environment' in which the person's problems would disappear.[1] She uses the analogy of a water kettle: a kettle with a three-pronged plug doesn't work in a two-holed socket, but that doesn't mean there's anything inherently wrong with it. If we use a

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[1]   We should likely interpret this as a necessary rather than sufficient condition. Robert Chapman points out – personal conversation – that early-stage Alzheimer's might otherwise serve as a counterexample. In early stages, the person might do fine in an adjusted environment, but we still consider it an illness – perhaps because of its progressive nature, perhaps for other reasons, too.

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suitable test – plug it into a three-holed socket – and it boils water under those conditions, it's fine. However, we can't say it's fine just because the water inside would boil if we hung it over an open fire – a kettle which only boils water under those conditions is still broken. So how radically changed may a 'test environment' be? Cooper doesn't say, but admits that it's at least partly an ethical and political issue. Still, much of Cooper's text is focused on criticizing Laing and Esterson's 1960's schizophrenia theory according to which it's a family problem rather than an individual disorder. They don't, she writes, show that there's any environment in which their interviewed schizophrenia patients function fine. Though she doesn't rule it out, she seems doubtful that any such unproblematic test environment can be produced for schizophrenia.

Alison Jost's (2009) critique of Mad Pride provides a good example of implicit use of the concept. Jost writes that a social model might provide an adequate framework for discussing many disabilities and disabled people's problems, but it won't work for mental illness. She writes: 'Most mental illnesses for most people are inherently negative […]. No matter how destigmatized our society becomes, mental illnesses will always cause suffering'. She acknowledges that stigma can be a big problem for both physically and psychiatrically disabled people. Still, Jost argues, being psychiatrically disabled or mentally ill is, in addition to the stigma, *inherently* bad. But Awais Aftab and Mohammed Abouelleil Rashed (2021) criticize her claims – how do we determine when society is sufficiently destigmatized? What would such a society look like? Can we really be confident that mentally disordered people would still suffer then? In effect, Aftab and Rashed question whether Jost imagines a sufficiently wide range of test environments.

3. Popular Media Debates with a Narrow Range of Test Environments

Neurodiversity advocates often focus on quite small changes in the school environment or workplace. This isn't inherently problematic: many people only require fairly small changes to function well, and writers may naturally focus on what has helped them personally. It is also worth drawing attention to how many people might actually require fairly small adaptations, even if they initially seem quite disabled. Nevertheless, it's a problem if these often-discussed small workplace changes end up creating paradigms for which test environments we should use in thought experiments or actual experiments to see

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whether someone is mainly disabled by external circumstances or suffer from inherent, neurological impairments. For instance, some autistic advocates write about how they need a sufficiently calm office space and the opportunity to work from home a few days a week. It's disabling for them to demand that they come to the office each day and work in a glaring light with noise from other people (De Vries, 2021; Enright, 2021). These are also the kind of adjustments that can be demanded by disabled people in US workplaces under the American with Disabilities Act, the Disability Discrimination Act in the UK, and similar legislations in other countries. The adjustments are important to discuss and sufficient for some disabled people, but not for everyone.

An extremely narrow view on what environmental changes we might make to better accommodate disabled people in the workplace is presented by Nancy Doyle, the founder of *Genius Within*.[2] She writes that there's a new workplace threat to disabled people – computer algorithms used to assess employees' productivity (Doyle, 2022). She focuses on how such algorithms judge everyone *by the same standard*, regardless of which diagnoses they might have.

Now, perhaps one might ease the stress of disabled people in such computer-supervised workplaces a teeny bit if the algorithms somehow took disabilities into account. Maybe some psychiatrically disabled people would do quite well under those conditions. However, looking back on my own life and times when I was much more distressed than is presently the case, I would likely have cracked under the pressure of constant productivity supervision *regardless* of whether the algorithm was programmed to give me some slack due to disability. I'm sure I'm not the only psychiatrically disabled person for whom this would be the case – and who might therefore be seen as neurologically impaired rather than disabled by an inhospitable environment, if it were the case I worked in that kind of place. 'We fixed the algorithm, we made it take disabilities into account, and these people *still* suffered mental breakdowns? The problem must be in their brains, then. Nothing more to do'.

4. How Many People Become Impaired in Different Environments?

Cooper is not interested in what might cause a condition to arise in the first place; she explicitly focuses on whether an already disabled

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[2]   Described, in her Forbes writer's profile, as 'a company specializing in neurodiversity and disability inclusion at work'.

person might do well in a different environment, or struggle in every relevant test environment. However, I will discuss *causes* in this section before returning to the issue of how different environments affect the already disabled.

There's a traditional version of the Social Model of Disability which distinguishes impairments from disabilities (Oliver, 1996, p. 22). On this view, *impairments* are (in one way or another *negative*) bodily or mental traits that are turned into *disabilities* when societal barriers of various kinds prevent impaired people from full participation in society. Philosophers who see themselves as adherents of some version of the Social Model debate to what extent it's feasible and desirable to draw a line between impairment and disability. On the one hand, talking about inherently negative impairments as something residing in people's bodies and/or minds might seem like a problematic concession to the medical model.[3] On the other hand, if we get rid of the 'impairment' concept, how do we explain that, e.g., the physical trait of having dark skin isn't a disability, even though it's stigmatized in many societies? Theories that deal in 'marginalized functioning' (Jenkins and Webster, 2021) or 'non-normative functioning' represent attempts to navigate this problem. Radical social model scholars may still struggle with how to reconcile the idea that, e.g., it's horrible if a company pollutes a poor area in a global south country so that more and more babies are born without limbs, with the idea that disability isn't some inherent tragedy. Eli Clare offers a nuanced and, well, *brilliant* discussion without arriving at any easy answers in his *Brilliant Imperfection: Grappling with Cure* (2017). I can't, in this chapter, dive deep into these tensions. I will, however, use the term 'impairment' in this section in its admittedly problematic traditional sense – though I will complicate the matter in later sections.

As long as people are willing to use the term 'impairment' in the first place, they will readily acknowledge that the external environment may cause impairments, and that there may be widespread problems in society that cause an unnecessarily high number of impaired people. Suppose, for instance, that some country has terrible traffic. Car crashes happen often, and many people drive cars that would be considered unacceptably unsafe in most other countries. Because of this, many people end up losing a leg or two or breaking their spines in car accidents, and subsequently use wheelchairs. An adherent of the medical model, who believes that we should ideally find

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[3]   Shelley Tremain (2001, p. 632) writes: 'impairment has been disability all along'.

some way to, e.g., mend all the nerves in previously broken spines so that people can walk again rather than having them roll around on wheels, would presumably *also* want to improve the traffic and car situation so fewer people end up in wheelchairs in the first place. A traditional social model theorist would agree. Of course we should build ramps and make society more accessible to wheelchair users, so that they aren't disabled in addition to being impaired – but we should also improve traffic so that fewer people become impaired in the first place.

Before moving on to psychiatry, I want to stress that I'm really focusing on the *impairment* here, not the *diagnosi*s.

I count as perfectly able-bodied by society. I regularly lift heavy weights at the gym and go for long daily walks with my dogs without problem. Nevertheless, it's difficult for me to further improve my stamina through aerobic exercise – I must push myself *much* harder than the average person to see results (see Montero and Lundby, 2017, for research on this physiological difference). This isn't considered a disability in our society, because marathon running and similar activities are entirely optional. However, if society, for some reason, came to demand more and more long-distance running from people in general, I might eventually end up diagnosed with the newly recognized disability Aerobic Low Response Syndrome, and have to ask for various special adjustments. In this hypothetical situation, society would have turned a non-disabled body into a disabled one, but not by changing my body or giving me any new impairments, only by changing its demands and expectations. Analogous things may, of course, happen on the mental level. But I'm here concerned with the mental analogy to car crashes that break people's spines so that they must use wheelchairs, not the mental analogy to a society where everyone is expected to be a long-distance runner.

Now, let's apply the traditional social disability model to schizophrenia. Let's say that schizophrenic people are first impaired by, e.g., frightening hallucinatory experiences and ego disturbances. Second, they are disabled by being stigmatized and excluded from society in various ways. Just like we should build ramps for wheelchair users, we should try to destigmatize schizophrenia and get better at involving schizophrenics in various ways. However, just as we should make traffic safer so fewer people need wheelchairs in the first place, we should also try to make society, e.g., less racist, so fewer people of colour develop schizophrenia in the first place – research shows that being a person of colour in a racist

society dominated by white people is a serious risk factor for paranoid schizophrenia (Bentall, 2004; Halpern, 1993; Boydell *et al.*, 2001).

Despite the tendency in popular science articles to focus on genetics and neurology when discussing mental illness and psychiatric disabilities, there's a large body of research on how both a dysfunctional family life and other kinds of individual trauma (e.g., Popovic *et al.*, 2019; Quide *et al.*, 2018), and society-wide problems like racism and poverty can cause (in conjunction, of course, with genetic and other factors) mental impairments that range from depression to schizophrenia. I've already mentioned research on racism and schizophrenia. Lund *et al.* (2010) also found a strong correlation between common mental disorders and poverty – more specifically, low education, low socio-economic status, food insecurity, lack of housing, and financial stress – in their meta-analysis of 115 studies. They conclude that developmental agencies and international developmental targets should include mental health goals, because this is something that we can plausibly affect.

The causal relations behind the correlation are likely complex – it's possible to first develop a mental disorder, and as a result lose your job and become poor. Perhaps some people become poor because they have a mental disorder whereas others become mentally ill because they're poor, and for some, it's a vicious cycle where it's impossible to determine which came first. Different researchers stress different causal pathways – from poverty to mental illness, or the other way around. Nevertheless, there are also intervention studies looking at the mental health effects of unconditional cash transfers to poor people. Doing so improves well-being and physical markers such as cortisol levels for poor people in general, and improves symptoms in those already diagnosed with mental disorders (e.g., Ljungqvist *et al.*, 2016; Fernald and Gunnar, 2009; Haushofer and Shapiro, 2016). Given all this, it's unlikely that poverty's impact on the frequency of mental disorders in a population is small enough to be dismissed.

However, political discourse tends to treat the frequency of psychiatric disabilities in the population as impossible to influence via political decisions; 'taking the problem seriously' means increased awareness, encouraging people to seek mental health treatment, perhaps increased funding to mental health services, and perhaps some workplace adjustments of the kind discussed above, but nothing more large-scale. This is a serious problem and needs to change. Schizophrenic and otherwise psychiatrically disabled people *should* have access to good mental health care, a destigmatized environment, and any special adjustments we might need to work or

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study – but we must not forget that we would likely see fewer people getting schizophrenia in the first place if society were less racist, less impoverished, and less fiercely competitive.

5. Relevant Test Environments for Already Disabled People

Environmental factors not only cause impairments to arise in the first place, they can also worsen them and prevent recovery. For instance, T.M. Luhrmann (2007) writes that the best explanation for the vastly different recovery rates seen between American and Indian schizophrenics, in otherwise similar urban populations treated by similar psychiatric systems, is that the former often are homeless whereas the latter usually have homes. Job stress leads to more frequent sick leave and hospitalization for people with mental health conditions (Duchaine, 2020).

It's crucial to see that these problems are often society-wide rather than something that can be fixed locally in the workplace. Suppose that Stina is very stress sensitive, and therefore granted accommodations like a quiet workplace without glaring lights, and the option to work from home a couple of days a week. If she lives in a highly competitive society in which employers have the right to fire anyone anytime they please and often do so, Stina might still be highly stressed due to these background conditions. However, if Stina and/or people around her are so used to living in a competitive society without job security that they never stop to ponder whether things could be different, they might end up thinking of Stina as mentally *impaired* by her stress sensitivity – after all, she *still* suffers, even *after* she got all these accommodations!

When imagining Stina in different test environments, we should also envision her living and working in an overall less competitive and more secure society. As Cooper writes, there's no objective, value-neutral answer as to the range of test environments that would still count as relevant. Perhaps we might think that some highly utopic society that we dream up, or a society where everything revolves around Stina and her needs, isn't realistic or relevant. But shouldn't we, at least, try to imagine how Stina would fare in, say, a social-democratic state with strong labour unions and strong job security (preventing Stina's boss from threatening to fire her or harassing her for not being sufficiently productive) and a strong welfare system (so that even if she were to drop out of the job market, she could live a good life on welfare)?

Perhaps we – or Stina herself – have no way of knowing how well she would fare or function in such a society. If so, we should at

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least admit as much – not confidently state that Stina's problem is inherent/neurological/medical in nature.

6. Autobiographical Case Study: How I Went from Applying a Medical to a Social Model to Myself when Getting a Better Environment

I think my own case can provide a nice illustration of how difficult it can be to use something like Cooper's 'test environments' in practice to distinguish neurodivergences from impairments, and how easily we might be mistaken about *our own* case.

Since I was a child, I have experienced myself as sliding back and forth between normal reality and a terrifying demon world. I have written about these problems elsewhere (Jeppsson, 2021, 2022b, 2022c, 2022d), and won't go into much detail here; suffice to say that I have spent *so much time* in a state of *absolute terror*. Therefore, I used to think that the social model wasn't really applicable to my own case. Sure, having schizo-something-or-other[4] is stigmatized, and people might give you weird looks if you say that you've been hospitalized for psychosis. Nevertheless, I used to think that stigma accounted for very little of my problems. I used to think, like Alison Jost, that in a hypothetical completely stigma-free situation, I would still suffer horribly from *being chased by demons*. I would still suffer horribly from *the terror*. Intense terror, just like intense pain, is *inherently* bad, regardless of how much other people accept you.

One reason I thought of my problem as medical, not social, was that I imagined myself as I was, with the same terrifying experiences and the same subsequent emotional states, placed in different environments – I failed to foresee that my mental states would change as radically as they did when the environment changed (a common implicit assumption, see Penson, 2015). Another reason is that my environment seemed pretty good. I was married to an incredibly supportive and helpful man, I got to work with philosophy which I found very interesting, most of my colleagues at work knew that I had schizo-something but were tolerant enough, and so on. Sure, I did a long weekly commute to another city which wasn't ideal. My husband had a very stressful job, and I empathized with and felt sorry for him without being able to do anything about his job problems. I constantly searched for permanent jobs at the highly

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[4] I have never been precisely diagnosed, beyond 'you're in the ballpark of schizophrenia but doesn't quite tick enough boxes'.

competitive academic job market since I had, so far, only managed to land fixed-term ones. But none of these problems seemed, in any way, extraordinary; rather, lots and lots of people have similar struggles. That's just life.[5]

Then the following happened: I got a permanent philosophy job with good job security and a good salary, my husband could quit his job, we moved close to my new university so I didn't have to do a long commute anymore, we moved to a nice big house, close to forests and the sea where I take long walks with my dogs – in short, my life became much less stressful and much more idyllic. In fact, my life became so good and stable that I managed to quit my anti-psychotics and other medication and still function without any relapses into florid psychosis. I saw a therapist who helped me get over some internalized stigma and shame that I hadn't even been aware of, which in turn allowed me to freely experiment with various mental tricks and coping mechanisms until I found ones that worked. I began writing and publishing about my own madness, *fully* came out of the madness closet in a way I hadn't dared to do while still on the job market, and was met with tons of appreciation in response.

Not only do I realize, in hindsight, exactly how stressful my previous life had been – I also realize now that it was a mistake to imagine myself *still chased by demons and still full of terror* in different scenarios and then ask whether I would still suffer. It's been five years now since my life changed to its current idyllic and stable state, and during that time, my truly horrible and frightening experiences have gradually subsided. Now, I'm almost never frightened of demons.

This is not to say that I have become *sane* and *normal*. I still experience plenty of little hallucinations and illusions of various kinds, I still often feel like a tiny creature lodged inside the skull of a body which I drive but which isn't identical to me, I still experience sliding in and out of different realities, and so on – but all these experiences are far less frightening, much more benign nowadays.

I'm still mad. I'm also happy to call myself neurodivergent. But I'm far less *impaired* than I used to be – hardly at all, nowadays. And this is one important reason why the previously used distinction between impairment and disability is oversimplified. The environment doesn't just determine how much a given impairment

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[5]   I've had these psychiatric problems long before I entered academia, but it was the same back then – my life seemed pretty fine to me, even though there were sources of stress too, but nothing extraordinary. So it didn't seem to me in my pre-academic state either that the environment might play a major part in my suffering.

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becomes an obstacle, it also continuously influences and shapes our impairments – sometimes to the point where they cease *being* impairments and turn into something else.

How many people diagnosed with a serious mental disorder could, hypothetically, experience the same improvement? How many could be neurodivergent rather than impaired if their external environment and overall life situation became *truly* good? I don't think this is possible to say. But we should, at least, *admit* that we don't know, instead of confidently talk of which conditions are always impairing and suffering-causing regardless of environment. Such confidence only betrays a limited imagination when it comes to test environments.

7. Stigma, and Different Environments to Come Out In

I believe that we often focus too much on stigma and not enough on other problems when discussing environmental obstacles that psychiatrically disabled people face. Nevertheless, destigmatization is important. But it's worth asking, with Aftab and Rashed (2021), what it means for an environment to be fully destigmatized. People often assume that there's no stigma if a psychiatrically disabled person can disclose their condition without facing negative reactions or consequences for so doing. However, information campaigns and medical advice sites often take a narrow view on what proper disclosure should look like. Australian government-funded website *Health Direct* advises psychiatrically disabled people on what *they* can do to help decrease the stigma: 'If you have bipolar disorder, say "I have bipolar disorder", not "I'm bipolar". If you convince yourself first that you're a person, not a walking illness, others will find it easier to see you that way too'. This is quite typical advice from this kind of site. You're supposed to explain to people that you're essentially a normal person like everyone else, except that you carry this regrettable illness around.

There's nothing wrong with seeing your psychiatric condition as something you *have* which is distinct from *who you are* if that works for you (Jeppsson, 2022a). But it doesn't suit everyone; an environment in which this is the only way one may disclose without facing backlash is still severely stigmatizing for many people.

I can't honestly say that I'm a pretty normal person who merely *has* schizo-something. I'm mad, that's who I am. I wasn't fully aware of how constricted I felt when I still kept one foot in the closet because I was afraid of discrimination. But since I got job security and fully came out, it's been an enormous relief and boost for my self-esteem.

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An environment isn't stigma-free until it's perfectly okay, not only to say that you *have* a psychiatric condition, but also okay to *be mad,* to *be neurodivergent,* and, in general, to *be as weird* as you need to be.

8. Conclusion

We may try to determine whether a psychiatrically disabled person's problems are mostly external/social or mostly internal/neurological by placing them and/or imagining them in different environments, exploring whether there is any environment in which they're happy and functional. However, we're often quite unimaginative when thinking of different environments; often, we should widen our scope.

Politicians, corporate leaders, and other people in power often have a vested interest in taking the status quo for granted and label people inherently disabled or impaired if they fail to respond to relatively small, cheap, and local adjustments – it's important that we keep questioning such politically motivated conservative assumptions. Moreover, we should acknowledge how difficult it might be to imagine *oneself* in radically different circumstances. Even if it's true that I would continue to suffer if I, hypothetically, were placed in a great situation but retained the exact same emotions (the exact same hallucinations, *etc*.), we must remember how difficult it may be to predict how this new situation would, in reality, *affect* and *change* my emotional state (my hallucinations, *etc*.).

The fact that we tend to use a narrow range of test environments has important practical implications. There are important implications for assisted suicide/voluntary euthanasia for psychiatrically disabled people, insofar as euthanasia is supposed to be for people whose suffering is inherent/medical only. It also matters for the new eugenics debate, and for claims according to which we should try to eradicate, e.g., schizophrenia from the population. Finally, politicians who claim to take psychiatric disabilities and mental illnesses seriously should be called upon to do more, to improve society, rather than merely promoting anti-stigma campaigns and funding psychiatry.

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