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**Title:** Madness-as-strategy as an alternative to psychiatry's dysfunction-centered model

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**Abstract:** A broad base of agreement among the contributors to this volume is that there is a distinctive paradigm called "psychiatry's medical model," "medical psychiatry," or "the medical view of psychiatry." Because of a complex array of institutional, economic, social, and political factors, this model has become so deeply entrenched in our collective thinking about madness that it can be hard to see a way out of it. In the following, I present, on the basis of extensive historical research, one particular alternative. I call it madness-as-strategy and oppose it to the now-dominant view, which I call madness-as-dysfunction. My goal here is to clarify the meaning of madness-as-strategy, to show how it surfaces repeatedly throughout the history of madness in different forms and guises, to gesture toward some contemporary research projects that exemplify this framework, and to describe its continuing relevance.

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## Some Working Assumptions

These reflections stem from a basic set of assumptions that I believe I share with all of the volume's contributors. These are a set of postulates that won't be defended here, but that will be adopted as working assumptions – as the intellectual soil for new growth. I will enumerate seven of those postulates.

First, there is *something* – a set of beliefs, a way of seeing, an intellectual paradigm – called medical psychiatry or the medicalized view of psychiatry. Though this vision has been with us for millennia, it has in the last few decades managed to become so deeply entrenched in the public conversation about mental health in the West that it can be hard to even see it as a distinctive paradigm, much less to envision alternatives. I have documented this extensively in my book, *Madness: A Philosophical Exploration* (Garson 2022), and the following represents a distillation of the core points.

Second, this medical vision manifests itself through empirically observable facts: for example, that at least 15% of the population of the UK are on antidepressant drugs[1]; that one in five

[1] https://www.bbc.com/news/uk-scotland-66430817.amp

American college students are on psychiatric drugs[2]; that there is a $30 billion plus industry that seeks to promote disease-centered framings of mental health problems and that thrives on their basis, and the conceptual foundation of which is the belief that mental distress represents a medical problem akin to diabetes or cancer.[3]

Third, there's likely no one person, or small group of people, to blame for the entrenchment of the medical vision. It probably represents the outcome of the confluence of various psychological, sociological, historical, and institutional forces – in addition to powerful personalities such as Robert Spitzer (Wakefield in prep) or Solomon Snyder (Garson in prep) – forces that are appropriate subjects for historical and sociological analysis (e.g., Moncrieff 2013; Harrington 2019).

Fourth, a core intellectual mission of medical psychiatry's critics is not merely to expose how deeply entrenched it has become, but to explore alternative, more empowering framings for making sense of and coping with the distressing, disturbing, extreme or unusual experiences (modes of cognition, forms of interpersonal interaction, etc.) that currently fall under the rubric of "mental disorder."

Fifth, this medical vision, though not without benefits for some suffering people, has extensive and well-documented harms, both harms associated with overmedication and subsequent withdrawal symptoms, as well as relational and emotional harms of framing one's experiences or choices as the byproduct of an inner dysfunction or disorder (e.g., Kvaale et al. 2013; Lebowitz and Ahn 2014; Haslam and Kvaale 2015; Pescolido et al. 2021; Schomerus et al. 2022; Schroder et al. 2022). Other harms include the fact that, by seeking to explain distress in terms of a breakdown in the individual, it often draws attention away from relevant social and political causes of suffering and thereby neutralizes attempts to address those causes directly (e.g., Davies 2021).

Sixth, psychiatry has not, contrary to some of its proponents, abandoned this medical model; rather, it tends to reaffirm it under various guises. For example, what is sometimes called the bio-psycho-social model is, often enough, just one guise under which this medical vision asserts itself (Read 2005). That is because, on at least one natural way of understanding what the bio-psycho-social model is, it is simply a way of seeing one's mental health problems as the result of an inner dysfunction that is precipitated by psychological and social factors.

Seventh, this model additionally manifests itself through the proliferation of disease language, that is, the disease-related terminology that has permeated the way we talk about mental health: "disorder," "dysfunction," "intervention," "diagnosis," "prescription," "medication," and so on (Johnstone 2022). In Eleanor Longden and John Read's (2017) memorable words, this vision is unable to see "people with problems" but only "patients with illnesses."

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[2] https://www.statista.com/statistics/1126744/percentage-of-college-students-using-psychotropic-medications-us/

[3] https://www.globaldata.com/media/pharma/global-sales-of-psychiatric-drugs-could-reach-more-than-40bn-by-2025-due-to-coronavirus-says-globaldata/

That said, how can a philosopher and historian of ideas intervene into this medical vision?

In my academic work, I study the history of madness, with special attention to the ideas and intellectual frameworks that coexist or succeed one another in various eras. This work has not only helped me to appreciate the historical contingency and fragility of our current medical framework. It has also led me to identify a handful of recurring motifs that, historically, permeate our thinking and theorizing on the topic of madness. (Note that I generally prefer using the term "madness" to terms like "mental disorder" or "mental illness," as I want to move away from these quasi-medical framings. I realize that "madness" is not a perfect term, because it alludes primarily to psychosis; it doesn't typically incorporate experiences like sinking into a deep depression, experiencing overwhelming panic, having difficulties understanding the expectations of the social world or adjusting one's behavior to meet them, and so on. But I will use the term "madness" anyway, with the qualification that I mean it to include a broader range of experiences than the term usually connotes.)

It is tempting to think about the history of madness as an unmanageable plurality of different viewpoints that arrange themselves chronologically ("in the West, the mad were first thought to be shamans; then they were thought demon-possessed; then they were thought lazy; then they were thought infantile; now they are thought diseased…"). Even historians as perceptive as Foucault (2006/1961) or Scull (2015) sometimes suggest such a picture. I found, rather, that there were two main viewpoints that seemed to crop up again and again but in such diverse guises that it was sometimes difficult to see them as variations on a theme. Moreover, I found that, rather than chronologically alternating with one another, they seemed to exist everywhere simultaneously, with one or the other enjoying a slight dominance in the public and professional imagination at any given time. I've called these two paradigms madness-as-strategy and madness-as-dysfunction.

My goal here is simple. I begin by articulating what I mean by this distinction, and how my distinction differs from the traditional distinction between "biogenic" and "psychogenic" perspectives. Then I illustrate how these two paradigms (framings, perspectives, ways of seeing) have alternated and sometimes moved hand-in-hand throughout the history of madness. Finally, I show how madness-as-strategy represents a powerful alternative to psychiatry's medical vision, and indicate some of the current research that exemplifies it and that will continue to make this paradigm relevant far into the future.

**Madness-as-Dysfunction**

The first point of view that we can use for thinking about madness is what I call madness-as-dysfunction. The basic idea is that when somebody is mad, something inside of them isn't working the way that it's supposed to; something isn't working as it ought, or as nature intended. If we think of the sane mind as a well-functioning machine, the mad mind represents a machine with one of its cogs loose, or misplaced, or its parts disarranged. From the standpoint of madness-as-dysfunction, the doctor's job is, at least in theory, quite simple: it is to figure out what exactly went wrong within the mad person and fix it.

A crucial point about madness-as-dysfunction, and what makes my approach differ from the approach many historians have adopted, is that madness-as-dysfunction isn't wedded to a *biological* vision of the mind. It is not the same thing as the view that sees mental disorders in terms of brain dysfunctions. Rather, the operative idea is the more abstract notion of something not "working right." Something is broken. The "something" that is broken could be a biological sort of thing. It could be that one's brain is broken (dysfunctional, defective) in that it is producing too much dopamine or too little serotonin, and this chemical imbalance somehow distorts our ability to gate sensory perceptions accurately, which in turn leads to hallucinations, delusions, or mood fluctuations. It is possible, however, to think that this inner "something" that is broken, is broken in a purely psychological way. For example, cognitive behavioral therapists often describe panic disorder, in terms of a dysfunctional and self-perpetuating pattern of thoughts, feelings in actions (e.g., Clark 1997) This is a way of seeing something broken or dysfunctional inside the patient – but it is not a biological something. It's a psychological something. I count this, too, as an instance of madness-as-dysfunction.

Madness-as-dysfunction is by no means a new paradigm. It goes back thousands of years, at least in the West. The Hippocratic author of *On the Sacred Disease*, probably penned around 400 BC, tells us that all of the different varieties of madness involve a disruption of the flow of air to different parts of the brain. As I have argued in my book (Garson 2022, Chapter 1) the real originality of the Hippocratic vision is not that it frames madness as natural (rather than supernatural), but as the byproduct of an inner brokenness.

Madness-as-dysfunction resurfaces again in Late Renaissance Europe, in the duels between the physicians and the exorcists about specific forms of distress. For example, suppose a group of investigators are presented with a young woman with symptoms such as "*suffocation* in the throate, chowing of Cockes, barking of Dogges, garring of Crowes, frenzies, convulsions, hickcockes, laughing, singing, weeping, crying, &c." (Jorden 1603, 2), and the exorcist diagnoses demonic possession. Physicians like Edward Jordan, in contrast, argued that it resulted from a natural organic pathology: "suffocation of the mother," also known as hysteria. According to Jorden, hysteria takes place when the womb detaches from its ordinary position in the body and begins to press into and disrupt various organ systems.

This dysfunction-centered orientation became standardized in nineteenth-century psychiatric textbooks, such as those written by Cox (1806), Rush (1835), and Spurzheim (1836). It also formed the intellectual backbone of the period, in late nineteenth century Germany, which historians sometimes describe as "German imperial psychiatry" (Engstrom 2003). This dysfunction-centered view reaches a zenith in the writings of the great nosologist, Emil Kraepelin. I think, for various social, political, and economic reasons that are impossible to delve into here, madness-as-dysfunction had, by the 1980s, managed to practically eliminate alternative frameworks.

**Madness-as-Strategy**

In contrast to madness-as-dysfunction, the point of view that I call madness-as-strategy holds that when somebody is mad, everything inside of them is working exactly the way it is supposed

to. Everything is working exactly as it ought. Perhaps madness has a function or a purpose, and if we could just unlock that purpose or reason, we would have the key to healing and wholeness. Again, the goal is not to divide up the history of madness into biological and psychological points of view, where "madness-as-dysfunction" is synonymous with the biological perspective and "madness-as-strategy" with the psychological perspective. It is to divide it into those thinkers who primarily see madness in terms of its intrinsic purposiveness, and those who see it as a breakdown or violation of this purposiveness. Put as simply as possible, the proponent of madness-as-dysfunction is inclined to make sense of madness as the result of a broken mechanism; that of madness-as-strategy as a well-functioning mechanism. Like madness-as-dysfunction, madness-as-strategy resurfaces in different times and in different eras.

I don't want to be overly simplistic. We cannot classify specific thinkers in a very sharp way. We often see some intermingling of both of these themes in any particular thinker or theorist. In this respect, describing theorists as falling into two camps is sort of like describing Americans in terms of whether they are politically "liberal" or "conservative." Distinguishing people in that way does not imply that conservatives have no liberal beliefs, or liberals have no conservative beliefs, or that there are some people who fall somewhere in the middle. It's meant to capture an unmistakable trend of thought, a firm disposition to view social problems in certain ways and to pursue certain types of solutions.

One thinker that exemplifies the madness-as-strategy viewpoint in a fairly strict form is the early seventeenth century theologian and scholar Robert Burton (1577-1640), who penned *The Anatomy of Melancholy*. He often describes melancholy and other forms of madness as having a *divine* purposiveness. At the time, one of the core theoretical problems of madness was: why would God allow madness? Why would God allow such terrible suffering to befall his beloved children? The answer that Burton gave is that madness acts both as a punishment for sin, and as a rod of correction – as God's wakeup call to the sinful individual: "He is desirous of our salvation…and for that cause pulls us by the ear many times, to put us in mind of our duties" (2001/1621, I. 132-3). Understanding the divine purpose of madness, he thought, might provide the tool for healing.

Madness-as-strategy also finds expression in the French physician Philippe Pinel (1745-1826), who is famously depicted as breaking off the chains of the mad patients at the Salpêtrière women's asylum in Paris and is known for promoting the "moral treatment of the insane." But Pinel had other radical ideas, too. One of his ideas was that certain kinds of psychotic episodes, which he called *accès de Manie*, are actually cathartic and healing. They're purposeful, not pathological. He likened them to fever, the body's natural mechanism for fighting infection. In general – and like fever, he thought – they should typically be allowed to run their course in a safe environment, with medical intervention (drugging, vomiting, etc.) used only as a last resort. Given time, he thought, they would be healed by the "salutary efforts of nature [*efforts salutaires de la nature*]" (1800, 267).

Another with similar views was the German Johan Christian August Heinroth (1773-1843), whose massive *Textbook of Mental Disturbances* was published in 1818. There, he describes one particular form of madness, which Schmorak translates as "insanity with dementia and rage" [*Wahnsinn mit Verrücktheit und Tollheit*]. This takes place when the patient slips from reality

into a kind of dream world, a world of hallucinations and delusions. But this slippage, he thought, was a coping mechanism for trauma: *nature itself*, he insisted, heals the patient by allowing them to escape, temporarily, from their troubles. This is not a disease but the manifestation of the mind's intrinsic design. In the best scenario, he thought, such cases would run their course and remit spontaneously.

I see Freud, likewise, as primarily a proponent of madness-as-strategy. Despite the fact that he occasionally used more dysfunction-centered terminology, he thought of many mental health problems, such as hysteria, phobias, obsessive thoughts, or delusions, as *strategies* rather than defects. They were *unconscious* strategies that the mind deploys to release the pent-up energy (libido) associated with forbidden ideas or desires. For example, consider his 1911 paper on Judge Schreber, "Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides):"

> And the paranoic builds [his world] up again, not more splendid, it is true, but at least so that he can once more live in it. He builds it up by the work of his delusions. *The delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction*.[4]

This basic vision, madness-as-strategy, was woven into the first edition of the American *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of 1952. DSM divides all of the "non-organic" mental disorders into three main classes: the psychotic, the neurotic, and the personality disorders. Intriguingly, each class is defined as a *different sort of coping mechanism* that the mind uses to deal with stressors. For example, the psychotic patient is described as coping with stressors by withdrawing from reality:

> …a psychotic reaction may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism and withdrawal from reality, and/or formation of delusions or hallucinations (APA 1952, 12)

Viewed in this light, one of the core intellectual transformations of the famous third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-III, of 1980, was not to implement a *biological* vision of madness. It was to implement a *dysfunction-centered* vision of madness. Right at the outset, the DSM-III Task Force insists, rather sharply, that *all* mental disorders involve "behavioral, psychological, or biological dysfunction[s]" rather than merely "[disturbances] in the relationship between the individual and society" (APA 1980, 6). This passage has a somewhat long and complex history that I cannot go into here (see Garson 2022, Chapter 14).

The reemergence, or entrenchment, of this dysfunction-centered vision of madness in the 1980s went hand-in-hand with the promotion, on the part of influential psychiatrists such as Solomon Snyder, of the idea that most mental disorders, such as schizophrenia, depression, ADHD, and

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[4] SE (12: 70-1). All citations to Freud refer to the volume and page number of *The Standard Edition of the Complete Psychological Works of Sigmund Freud*.

bipolar disorder, resulted from neurotransmitter abnormalities that could, in theory, be reversed or supplemented by using the right medication (e.g., Snyder 1986). Snyder (1976) himself formulated the "dopamine hypothesis of schizophrenia" and spent many years tirelessly promoting it and similar theories. As psychiatrist and historian Joanna Moncrieff (2013) has documented, such theories helped to solidify, in the public consciousness, the idea that mental disorders were brain diseases that could be cured, or at least managed, by pills. This is an era that I believe we are still waking up from.

There are signs, however of an emerging paradigm shift. One reason that I sought to develop this terminology and this historical analysis – that is, viewing the history of madness as a clash or confrontation between madness-as-dysfunction and madness-as-strategy, rather than a clash between psychogenic and biogenic perspectives – was to give us a conceptual *lever* to help lift us out of the dysfunction-centered vision. It seems to me quite impossible to move away from madness-as-dysfunction until we can see it clearly for what it is, and thereby begin constructing alternatives. Only then can we treat it for what it is: as a contingent historical formation, one that could, and quite possibly should, be changed.

I don't mean to suggest that madness-as-dysfunction is *never* an appropriate stance to adopt toward a specific mental disorder. To my knowledge, the mental confusion associated with Lewy body dementia stems from a buildup of misfolded proteins in the brain. I do think, however, that it's deeply morally problematic for psychiatrists, psychologists, and other mental health professionals to promote a dysfunction-centered vision as if it is the only scientifically credible framework. Rather, as I will argue shortly, I believe that as a rule, people have the right to be exposed to different frameworks for making sense of their suffering, so long as those frameworks are scientifically credible.

**Current research projects**

Before wrapping up, I want to describe four current research projects that exemplify madness-as-strategy, and that provide a welcome counterpoint to the entrenched madness-as-dysfunction perspective. These concern the way we think about depression, borderline personality disorder, delusions, and dyslexia, respectively. I think it's important to grasp the way all four of these projects manage to see purpose, rather than pathology, in various mental health problems, and to that extent they share a similar spirit despite their outward differences. I've been fortunate to be able to write about these in more detail in a blog for PsychologyToday.com, where one can find more information and citations to follow up on.[5] The point of this section is to summarize a large amount of evidence without attempting to document it extensively, as that documentation has been provided elsewhere.

My first example is depression. By the late 1980s, it became very common to think of depression as a byproduct of a chemical imbalance in the brain, a notion that was reinforced by the

[5] https://www.psychologytoday.com/us/blog/the-biology-human-nature

commercial success of Prozac and other antidepressant medications.[6] The theory that supported that notion – the idea that depression stems from low serotonin – has been all but refuted (Moncrieff et al. 2023a; Moncrieff et al. 2023b). At the very least, the evidence for that idea turned out to be far weaker than many of us were led to believe at the time.

In contrast, some evolutionary psychiatrists, such as Randolph Nesse (2000), have been promoting a very different point of view (for a recent overview of evolutionary psychiatry, see Abed and St John-Smith 2022). In this view, depression, far from being a brain dysfunction, has an evolved purpose.[7] Put differently, it doesn't represent a broken mechanism, but a mechanism that is serving its purpose exactly as "designed." Specifically, it represents the brain's evolved mechanism for showing a person that something in their life is going wrong and needs more attention. Although the details of these evolutionary theories differ somewhat, they share a common presumption that depression represents an evolved feature of the human brain, rather than a broken mechanism. If this view is correct, it would have profound therapeutic significance. For it would suggest that, in many cases, the right approach to treating depression is not to bombard it with medication, but to listen to what it's trying to say. Intriguingly recent evidence even shows that framing a person's depression as an evolved signal, rather than a chemical imbalance, may actually promote superior treatment outcomes (Schroder et al., 2022).[8]

A second example comes from the realm of (so-called) personality disorders, particularly borderline personality disorder (BPD). BPD describes a cluster of traits associated with deep mistrust of other people, volatile interpersonal relationships, impulsiveness, and sometimes self-harm. Until recently, it was common for psychiatrists to think of BPD as the result of a frontal lobe defect, or as a failure of executive functioning. But an emerging point of view holds that some BPD traits, such as mistrust, are survival strategies, not brain defects.[9] Some evidence suggests that up to 80% of people who've received a diagnosis of BPD have a history of trauma, abuse or neglect. From that point of view, it becomes far more plausible to construe (e.g.) mistrust as a perfectly coherent strategy for navigating a hostile social environment.

Suppose we choose to see BPD traits as survival strategies rather than brain defects. Two things, I think, immediately follow. First, we should discard the language of disease, disorder, and dysfunction – terms which, as the evidence is starting to show, only foment stigma, rather than alleviate it. Second, and more important, it suggests an important approach to treatment, where treatment is deemed desirable. For it would indicate that the best path forward is not to search for a hypothetical brain dysfunction, but to ask whether and how those strategies – strategies that

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[6] Whittaker provides a journalistic overview of the emergence of the chemical imbalance metaphor and the interaction of psychiatrists, journalists, and pharmaceutical companies in promoting it: see https://www.madinamerica.com/2022/08/psychiatry-fraud-and-the-case-for-a-class-action-lawsuit/

[7] https://www.psychologytoday.com/us/blog/the-biology-human-nature/202208/what-depression-may-be-trying-tell-us

[8] https://www.psychologytoday.com/us/blog/the-biology-of-human-nature/202306/how-seeing-depression-as-purposeful-may-promote-healing

[9] https://www.psychologytoday.com/us/blog/the-biology-human-nature/202208/is-borderline-personality-disorder-actually-adaptation

might have been sensible enough at one point in life – may have outlived their usefulness. It would prompt us to consider which alternative strategies might be more beneficial.

A third example comes from the study of delusions. Although the very idea of a delusion is hard to define precisely (see Bortolotti 2023 for discussion), we can think of them as bizarre beliefs that have no social sanction: that I'm the second coming of Christ; that God has given me a special mission; that a famous actress is communicating with me telepathically. Surely, delusions must represent some sort of brain dysfunction?

An alternative point of view holds that some delusions actually serve a protective function. They are designed to buffer the mind from a reality that is just too difficult to confront – a view that harks back to earlier views such as Heinroth of Freud. Recently, Ritunnano et al. (2022) described a whole class of delusions that are almost impossible to understand without recognizing them as an attempt to give the sufferer a sense of meaning, purpose, and significance in life.[10] Additionally, Isham et al. (2022) recently showed that there is a correlation between the grandiosity of one's delusions, and having a sense of purpose or significance in life. If this is right, it has deep therapeutic implications, for it suggests that the point of treatment is not always to bombard delusions with antipsychotic medications. The point, rather, is to try to figure out what the purpose of these delusions are, and to devise healthier strategies for achieving the same end.

My last example is dyslexia, though I suspect that similar points might be made about ADHD and, perhaps, some forms of autism.[11] Dyslexia is often described as a neurodevelopmental disorder that disrupts the ability to read or write well. Emerging evidence, however – evidence drawn from a variety of sources – suggests that dyslexia might actually represent an evolved cognitive style. In other words, it might be a unique style of processing information, one with its own strengths and trade-offs.

So, for example, there is evidence that people with dyslexia tend to excel at what one might call "big picture thinking." For example, there's evidence that they are quicker to notice when a painting depicts an impossible figure (such as M. C. Escher's *Waterfall*). They also excel at divergent thinking, the ability to devise multiple solutions to the same problem. In fact, some surveys suggest that up to one third of American entrepreneurs have dyslexia. This evidence points to the same conclusion that dyslexia is not a dysfunction but a distinctive cognitive style. It is quite possible that framing dyslexia as a distinct cognitive style could be extremely useful for young people who suffer from it, for it would help to imbue them with the sense that dyslexia gives them unique cognitive strengths rather than merely limitations (Taylor and Vestergaard 2022).

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[10] https://www.psychologytoday.com/us/blog/the-biology-human-nature/202209/grandiose-delusions-and-the-meaning-life

[11] On dyslexia, see https://www.psychologytoday.com/us/blog/the-biology-human-nature/202207/seeing-dyslexia-unique-cognitive-strength-rather-disorder. On ADHD, see https://www.psychologytoday.com/us/blog/the-biology-of-human-nature/202211/did-adhd-evolve-to-help-us

I suspect that for nearly any alleged mental disorder we care to name, there are at least two contrasting ways of understanding it, researching it, and framing it. We can frame it as the breakdown of a designed mechanism in the brain, or, alternatively, we can frame it as a designed mechanism in its own right. But it is important to appreciate that the fact that these two quite distinctive perspectives are *available* to us does not mean that there's no "fact of the matter" as to which one is correct in any given case. I've given reasons for thinking that, in many cases, depression, BPD, delusions, and dyslexia are in fact designed mechanisms, not dysfunctions. Continuing to uncritically promote a dysfunction-centered perspective on these or other mental disorders is, in my view, not only scientifically dubious but morally problematic.

**Conclusion**

I feel quite optimistic about the future of mental health framings. It seems to me that society is not only waking up to the fact that our language and conceptualization of mental health is mired in an entrenched dysfunction-centered framing, but we are also waking up to how harmful these framings can be and to the extent of alternatives to them.

To be clear, I do not hold that we should simply *replace* dysfunction framings with function framings, or that madness-as-strategy should be the new intellectual norm that governs mental health research for the next few decades until people find problems with it in turn. I'm quite aware, moreover, that there are mental health service users and ex-patients who have found some comfort in dysfunction framings of their distressing experiences, and I have no wish to rob them of this tool. What I want to insist upon rather sharply, however, is that people who have distressing, disturbing, or otherwise extreme experiences have a right to be exposed to *multiple, scientifically-credible* frameworks for making sense of and navigating those experiences. If someone comes to accept a dysfunction-centered framing, it should be because they have been exposed to diverse ways of making sense of their problems and they have selected that framework as the best path forward, for them.

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