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Madness or Mental Illness?: Revisiting Historians of Psychiatry

Tomi Gomory, David Cohen, and Stuart A. Kirk

Revised Version of:

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Tomi Gomory, Ph.D. (Corresponding Author)

Florida State University

Telephone: 850-644-2328 Email: tgomory@fsu.edu

Address: 3609 Donegal Drive, Tallahassee, Florida 32309

David Cohen, Ph. D.

Florida International University

Stuart A. Kirk, D.S.W.

University of California, Los Angeles

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Abstract

Is madness medical disease, problems in living, or social labeling of deviance? Does the word merely refer to behavior peculiar enough to be disturbing? Are the mad mad because of mental, physical, or environmental vulnerabilities? No one knows the answers to these questions because there is no scientific validation for any theory or specific causes of madness. Nonetheless, a view of madness as medical/bodily disease has been receiving concrete and rhetorical support from the government mental health bureaucracy, Big Pharma, mental health lobby groups, the organized profession of psychiatry, hundreds of thousands of providers of mental health services and countless books and articles. This article explores the role that medicalized language and its use by seven noted historians of psychiatry (Norman Dain, Albert Deutsch, Gerald Grob, Roy Porter, Charles Rosenberg, Andrew Scull, and Edward Shorter) might have played in shaping the contemporary view of madness as mental illness. The evidence we uncover suggests that historical “facts” about madness, much as psychiatric “facts” supporting the disease model, are shaped by belief, bias, error or ambiguous rhetoric rather than the facts of the matter.

Introduction

Thousands of volumes have been written over the centuries about the true nature and definition of *madness*. Yet, as the medical historian Roy Porter notes, our current definitions depend on the same tautology used in the sixteenth century, when Shakespeare wrote famously in Hamlet, "what is't but to be nothing else but mad?" (2002, p. 1). Porter's definition, the "generic name for the whole range of people thought to be in some way, more or less, abnormal in ideas or behaviour" (1987a, p. 6), adds little substantively but suggests that the word *madness* does have utility: namely, to conceptually capture within an apparently comprehensive category all those "abnormal" people who significantly disturb society and sometimes themselves. Porter importantly notes that "even today we possess no . . . consensus upon the nature of mental illness—what it is, what causes it, what will cure it" (1987a, pp. 8–9, see also Andreasen, 1997; Grob, 1983, p. 36; Scull, 1993, pp. 391–394). Despite "heroic" and enormously expensive medical research efforts over many decades, no genes or reliable pathophysiology that maps schizophrenia or any other "mental disease" has been found (Andreasen, 1997; Bentall, 1990; Boyle, 2002; Kupfer, First, and Regier, 2003). But even if such pathophysiology were found and some current "mental disorders" relegated to true physiological pathologies and disappear from psychiatric concern (as occurred, say, with epilepsy, general paralysis of the insane, and pellagra), at best only some people currently diagnosed as afflicted with a mental disorder would be identifiable by relevant biomarkers. The rest would remain mystifyingly *mad*.

Is madness medical disease; a person's unfortunate, incompetent handling of greater and lesser problems in living; social labeling of disapproved behavior; social

construction tout court? Or, more provocatively, merely a word for a semantic category referring to all manner of behavior peculiar enough to be publically disturbing at any given time? The hypothesized causes, determinants, or contributing factors are as perplexingly varied. Are the mad mad because of unbearable social pressures, because of mental, physical, hereditary, genetic, or environmental vulnerabilities? Or, because of some as yet unfathomable combination of all of these (Read, Mosher, and Bentall, 2004)?

Neither the many theories nor the implied causes of madness have been scientifically validated. Fifty years of scientific efforts revising the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder* categories, quantifying them, and statistically calculating perceived differences among them may not be the best approach to understand what *madness* means. Nonetheless, groups with enormous political, ideological, and economic clout have taken up one theory about madness in particular: that it is medical/bodily disease. This theory, best known as the psychiatric medical model[i], is supported by the government mental health bureaucracy under the leadership of the National Institute of Mental Health, the pharmaceutical companies, mental health lobby groups, the organized profession of psychiatry, hundreds of thousands of providers of mental health services from all professional stripes and perhaps just as importantly, tens of thousands of volumes of books and articles rhetorically supporting it.

Madness as a Word

Before anything else, madness is a word, a human artifact, a sign, stitched together to represent or echo something (abstract or concrete) related to human behavior or one's perception of this behavior. As a linguistic sign, *madness* becomes available for

our critical manipulation, but like all linguistic signs it need not be anchored to particular aspects of the material world. The word *trees,* for example, does not directly locate any specific trees in the observable world, nor does it specify what the particular limiting attributes of the categorical term trees are. It serves as a label for collecting many disparate types of plants judged to belong under the category "trees," though these plants may share few common elements other than their category name (for example banana trees and oak trees). Such a category might be called "disjunctive." According to Bruner, Goodnow and Austin (1986), "[w]hat is peculiarly difficult about … a disjunctive category is that [any] two of its members, each uniform in terms of an ultimate criterion [for example being living organisms], may have no defining attributes in common" (p. 156).

Words and categories matter. Immanuel Kant proposed that categorizing is a fundamental and necessary act of human survival: it helps people to make sense and perhaps to respond to and control the mysterious nonhuman noumena (*das Ding an sich,* the thing in itself) that makes up the "out there" that another philosopher, William James (1890), described as "one great blooming, buzzing confusion" (p. 462).

To recapitulate, words are semiotic tools, but they do not have any fixed meaning or direct connection to material reality or enjoy any consensus about their usefulness. So it is with the word *madness*, because it is a word first and foremost and, lacking immanence, its meaning is primarily determined by those responding to it. Indeed, the history of social responses to madness suggests an abundance of possible meanings, often contradictory (e.g., devil possession versus pathological personality organization versus brain disease versus inept training for social life versus a metaphoric haven for escaping

from wrenching difficulties). Trying to define what madness (or mental disease, mental illness, mental disorder) *really* is, has been and may continue to be a failure. Based on the poor track record of progress in objectively validating madness or its semantic substitutes, one might consider that ideas and behaviors, even the strangest, most frightening ones called mad, are just that: ideas and behaviors.

Unusual and scary behaviors (one's own or those of others) that attract attention and elicit powerful emotions challenge people to account for their existence. If no obvious explanation is found, often the best that one can do in response to the need for knowing why is to manufacture a word or phrase as an explanation that can safely contain all that puzzling and frightening content. Such a word provides ontological comfort that helps one regain the existential stability that was lost as a result of the encounter. In short madness is a disjunctive linguistic category label. The term *mad* has been that universal account for disturbing behaviors for hundreds of years. It is a linguistic black hole that (metaphorically) sucks in all peculiar human behavior that society cannot digest or normalize but still feels compelled to explain in order to respond to it or control it. The word serves to instruct the normal that boundaries distinguish the mad from the rest of us. It also strikes a cautionary note about what might happen if the normal are not vigilant and transgress. Our view is similar to the contention of Thomas Scheff (1966), who argued that "mental illness" was a "residual" category of deviance containing diverse behaviors that appear inexplicable to observers.

The word also serves to limit inquiry. Its invocation appears to explain by mere assertion. "Why is John's behavior bizarre?" Answer: "He is mad (mentally ill)." "How can we be sure that John is mad (mentally ill)?" Answer: "He exhibits bizarre behavior."

This process is tautological. However, the strength of the various institutions aligned to support and validate that illogical judgment—such as government (National Institute of Mental Health), business (pharmaceutical industry), the professions (psychiatry, psychology, social work, nursing), and the academy (distinguished professors from the helping professions conducting research)—effectively discourages exploring alternative explanations for John's bizarre behavior.

While reviewing several books on the history of madness as a foundation for a critical examination of the major Western psychiatric revolutions of the past half-century (community treatment, descriptive diagnosis, and psychoactive drug prescriptions) (Kirk, Gomory, and Cohen, 2013) we were struck by the importance of historians in establishing what most people, ourselves included, might take for granted about madness. We also discerned evidence in several historians' writings that some personal experiences or beliefs, more or less clearly acknowledged, might have shaped their historical accounts. With our discussion of the word madness as backdrop, we turn to some of the major contemporary chroniclers of madness to examine the role of their rhetoric and personal beliefs not only in "reporting" but in shaping the contemporary view of madness as medical illness.

The Modern Historical Chroniclers of Madness

The historians we shall discuss are, in alphabetical order, Norman Dain (1964), Albert Deutsch (1967), Gerald Grob (1973; 1983), Roy Porter (1987a; 1987b; 2002), Charles Rosenberg (2007), Andrew Scull (1979; 1993) and Edward Shorter (1997). Professor emeritus at Rutgers University, Norman Dain's major work is *Concepts of Insanity in the United States* (1964), which Gerald Grob (1973) believes is the best

academic discussion of early American psychiatric thinking (p. 153), and Andrew Scull (1993) calls one of "the best and most scholarly . . . accounts from this era" (p. 119). Albert Deutsch (1905-1961) was considered "a crusading journalist … [and] a historian noted for *The Mentally Ill in America* … unrelenting in his quest for improved conditions for individuals with little voice of their own (Weiss, 2011, p. 252).

Gerald N. Grob is the Henry E. Sigerist Professor of the History of Medicine (Emeritus) at the Institute for Health, Health Care Policy and Aging Research, Rutgers University. The dean of American psychiatric historians, over a thirty-year period Grob authored five major books (1966; 1973; 1983; 1991; 1994b) and dozens of articles detailing the history of American psychiatric care from its colonial beginnings through the dawning of the twenty-first century. He is also a past president of the American Association for the History of Medicine (AAHM).

The late Roy Porter was a professor at the Wellcome Institute for the History of Medicine in London, who edited or wrote over a hundred books and is probably, because of the rigor and prodigious academic fecundity of his writings, the most cited historian of medicine. Porter has published more than a dozen books on psychiatry and madness alone. That he managed to accomplish all of this before his early death in 2002 at age fifty-five makes his achievement even more impressive.

Charles E. Rosenberg is a professor of history at Harvard University, a fellow of the American Academy of Arts and Sciences, and a past president of the AAHM and Society for the Social History of Medicine. He has written or edited more than a dozen books and numerous articles on medical and psychiatric issues.

Andrew Scull is a Princeton-educated academic who currently is the chair of the

Department of Sociology at University of California, San Diego. He has published many books on the history of madness, is a recipient of the Guggenheim Fellowship, and was the president of the Society for the Social History of Medicine.

Finally, Edward Shorter, a professor of medical history at the University of Toronto, has also written several books on psychiatric history and social history, the best known being the 1997 work, *A History of Psychiatry.* In addition to these seven principal historians, we will reference other scholars who have contributed to the writing of psychiatric history.

Some Problem with Historical Messengers

The field of psychiatric historiography is reported to be "passionate, partisan and polemical" (Micale and Porter, 1994, p. 3). Yet, despite this implied diversity of perspectives, we believe that most historians of madness accept that what is contained within the category of madness is best understood as a form of *illness.* Illness usually is understood as a medical term, and some historians fully accept that madness is brain disease. However, because the term may be vague, its application offers wiggle room to historians who are unsure whether madness is physical disease, but nevertheless feel that "mental illness" is an illness in some sense. This ambiguous quality of *illness* provides opportunities for confusion in the presentation of the historical "facts" regarding madness. For example, Andrew Scull—in a rebuttal to a psychiatrist's attack that he, Scull, considers madness "merely a literary or a philosophical concept"—responds thus:

> If I am less inclined than Dr. Crammer to concede that the definition of madness as illness is a pre-social, "natural" feature of the universe, and instead regard the boundaries of what constitutes insanity as labile and

> greatly influenced by social factors, that is not at all the same thing as the assertion that "mental illness" is some sort of literary or philosophical conceit. (Scull, 1995, pp. 387–388)

Scull's viewpoint is based, he writes, on the fact that "like many lay people I . . . unfortunately have first hand experiences of the ravages of mental disorder on those near and dear to me" (p. 387). Scull is an important historian who has through his careful scholarship exposed some of the most egregious acts of terror and coercion in the field of psychiatry. He appears to consider madness an illness but is not ready to declare that it is a "natural feature of the universe," leaving his readers confused. Is madness to be considered a medical disease like any other? If not, how should his readers think of it? Since most contemporary laypeople (with whom he identifies in the second quote) think of mental disorder as a medical problem, his undefined use of *mental illness* and *mental disorder* will resonate medically to many of them.

Some historians narrate the history of psychiatry as a progress through time. In their accounts, primitive ignorance eventually gave way to the development and implementation of a scientific psychiatry through the key "discovery" that troubling and disturbing behaviors are medical diseases (Deutsch, 1967, pp. 517–518). Other historians take a more cautious position, believing that "the history of our responses to madness . . . is . . . far from being a stirring tale of the progress of humanity and science" (Scull, 1993, p. xvii). Finally, perhaps alone among those publishing psychiatric history, Thomas Szasz (1920-2012), a psychiatrist himself although his own counseling practice never relied on medical interventions, attempted to delegitimize psychiatry as a medical enterprise. He maintained that psychiatry was not a medical discipline to heal sick people but a unique

policing profession (because mental patients are not diseased). Szasz was often dismissed or excoriated by his psychiatric contemporaries for arguing that their management of madness is primarily a political, legal and moral endeavor. His works develop the notion that the metaphors of medicine served to convert state-supported policing activities of socially disturbing behavior into medical interventions for a public health problem (Szasz, 2007).

These differing accounts of madness and its psychiatric management expose as naïve the idea that psychiatric history proceeds by reporting facts and nothing but. In their book, *Discovering the History of Psychiatry,* Roy Porter and his co-editor Mark Micale write that "both empirically and interpretively, extant histories of psychiatry reveal a vastly greater degree of difference among themselves than historical accounts of any other [medical] discipline" (1994, p. 5). Over time, they argue, organic medicine has demonstrated dramatic scientific advances in its understanding of the nature and etiology of disease, but mental/psychological medicine has failed to provide a similarly unified explanatory framework for its targeted problems. Psychiatry is the sole medical specialty lacking physiological validation for any of its particular entities, including the ones it considers most serious and persistent (Kupfer et al., 2002). Thus, it remains an open question whether the psychiatric profession is treating medical diseases entailing impersonal pathophysiological processes, or instead responding to the moral and behavioral anguish of individuals failing in the game of life as Szasz and a few others argue.

The historical texts discussed here, while occasionally documenting the ambiguous ontological understanding of madness, nevertheless routinely employ

medically-impregnated language to tell their stories. Expressions such as *lunatic, lunacy, crazy, chronic mental illness, severe and persistent mental illness, mental illness, psychosis, insanity, the insane, psychotics, mental medicine, psychiatry, psychological medicine, mental disorder, disorder, mental disease,* and *disease* are used frequently and interchangeably throughout this literature. The habit of comingling words that are prone to ambiguous interpretations, such as *insane, crazy,* or *illness*, with others that also have more formal medical definitions in contemporary medicine, such as *disease* or *psychosis,* has consequences. As Scull suggests, "The concepts which we use to delimit and discuss any particular segment of reality inevitably colour our perceptions of that reality" (1993, p. 376). This comingling, we believe, betrays a medical bias, perhaps an unaware one. In other cases, the reverse might hold: the author's acknowledged medical bias shapes the historical account.

Micale and Porter's own characterization of the medical field's activities toward mad behavior as *mental medicine* exemplifies these conceptual difficulties. Even without knowing whether these two historians have empirical reasons for using that phrase, we can speculate about the cognitive impact on readers of seeing a professional field thus referred to matter-of-factly. Should readers think that the authors are naming a formal domain of medicine, or is the phrase meant as a literary flourish? If intended formally, do Micale and Porter imply that *mental* medicine should be held to the same scientific criteria and methodology as the other domain they identify as *organic* medicine? If meant metaphorically, should this be pointed out? Their essay does not provide answers to these questions, and the authors also employ expressions such as *psychological* medicine, further adding to the possible confusion.[ii] It would help if Micale and Porter had

explicated their claim that psychological medicine is "[p]oised precariously between the medical sciences and the human sciences" (1994, p. 5).

Through Metaphors Darkly

> As philosopher Murray Turbayne writes in *The Myth of Metaphor* (1970):
>
> We tend to forget that there are many subjects that we speak of only in metaphors . . . for example mind and God. The histories of the sciences of psychology and theology record . . . the unending search for the best possible metaphors to illustrate their unobservable subjects. . . .We find later theorists objecting to earlier metaphors that . . . have become obsolete. We find them substituting new metaphors for old ones that are either worn out by over-use or that present an unappealing picture. But we also find many of these theorists writing as if they were replacing false accounts of these subjects by true accounts, or as if they were replacing metaphorical accounts by literal accounts. (p. 96)

Political scientist Kenneth Minogue argues that certain words and phrases can effectively give the impression that mere opinions possess substantial empirical certainty and stability because of the power of their metaphorical imagery. He identifies these terms as "perceptual metaphors" (1985, p. 141). For example, when watching people, one does not, using one's senses, directly perceive the complex content suggested by the terms *lunacy, madness, disease,* or *illness*; instead one *sees* behavior (such as rocking, pacing, screaming, staying immobile) or *hears* reports and complaints of discomfort (claims of feeling light-headed, feeling pain, seeing unseen beings and things, receiving verbal commands to commit harm to self or others) or *views* signs of physiological

processes (hot forehead, abscess, swollen abdomen, rash, and so on).

In order to make sense of these observations, one relies on perceptual metaphors such as *disease, madness,* or *illness* to package and mold them. In choosing to attach the word *disease* to a set of perceptions that otherwise would be viewed as disturbing or offensive behavior, one is "implicitly claiming a conclusiveness which has not [necessarily] been demonstrated" (p. 141). This also serves to notify one's audience that *they* are expected to perceive disease too. Thus, the use of expressions like "mental disease" or "mental illness" for describing in historical texts certain *ideas or behaviors thought (by some) to be in some way abnormal or disturbing or like a disease* is not a neutral act. In the absence of an explicit clarifying statement by the author (i.e., "*disease* is here being used metaphorically"), these terms cannot but put their audiences into a medical state of mind or evoke medical conditions because most people have been taught and redundantly reinforced throughout their lives to associate those terms with medicine. To make our point more explicit, let us further examine some of the work of Andrew Scull. We use his work to make the point that even the most critical historians of madness and psychiatry may inadvertently promote a medical perspective. In *The Most Solitary of Afflictions*, Scull (1993) discusses the sad condition of one group under the purview of the mental health care system, whom he calls "younger psychotics" (p. 391). Psychosis can be the direct result of organic diseases like dementias, stroke, brain tumors, infections, and chemical overdoses, but the term is also applied to individuals who act quite strangely in the absence of any known organic cause. Scull, however, does not say how he intends his readers to understand these "younger psychotics": diseased or distracted? He writes:

> Psychiatrists and other social control experts . . . negotiate reality on behalf of the rest of society. Theirs is preeminently a moral enterprise . . . I would argue that . . . the boundary between the normal and the pathological remains vague and indeterminate and mental illness . . . an amorphous all-embracing concept. Under such conditions, there exists no finite universe of "crazy" people. (pp. 391–392)

Scull in this passage seems to support the notion that psychiatry arbitrarily constructs mental illness as a way to conceptualize, respond, and control marginalized social dependents. Furthermore, he suggests that this enterprise may have no logical limits, resting on an "all-embracing concept." But in an earlier section of the book, while criticizing Szasz's alleged position, he avers, "I cannot accept . . . that mental alienation is simply the product of arbitrary social labeling or scapegoating, a social construction *tout court*" (Scull, 1993, p. 5). What *does* Scull think mental alienation is the product of? In an earlier article, he includes a long note about the problem of using conventionally available terms reflecting a medical perspective, such as *mental illness*, when trying to write more or less neutrally about madness for a diverse audience. After explaining in some detail why there is no good way out of the dilemma, he concludes that "[f]aced with this problem, I have chosen to refer almost interchangeably to madness, mental illness, mental disturbance and the like" (Scull, 1990, p. 307, note 1).

Ordinarily, this would do. But Scull's note does not just contend that the terms *madness, mental illness, mental disturbance*, and the like do not have generally agreed-upon definitions and thus may be in some sense interchangeable metaphorically. He also asserts that madness itself, despite its ill-defined names, is real. He maintains, "To recognize that, *at the margin*[iii], what constitutes madness is fluctuating and ambiguous . .

. is very different from accepting the proposition that mental alienation is simply the product of . . . social labeling and scapegoating" (p. 307, note 1, italics added). Moreover, Scull believes that accepting *mental illness* as a socially-constructed reification would be denying the many visible negative outcomes associated with the problematic behaviors the mad engage in. Perhaps he is arguing that, for him, *madness,* when he calls it *mental illness*, is just another term for certain extremely troubling or troubled behavior that has dire consequences both for the person and others close to the person, and not, as often assumed by the laity, a medical problem. (It is hard to know unambiguously what kind of reality *mental illness* is for Scull.) Moreover, perhaps "younger psychotics" is referring not to medically ill individuals but to young people who have been waylaid by life's exigencies and have been the victims of the failure of our social welfare safety net. If that was Scull's intent, it might have been more useful to spell that out rather than resort to terms that have been associated with the medicalization of deviant behavior (Conrad and Schneider, 1992) and therefore easily misunderstood as medical. He depicts the mad as the recipients of "the enormity of the human suffering and the devastating character of the losses" resulting from madness and he suggests that the mad are therefore the "victims of this form of communicative breakdown" (Scull, 1990, note 1). Thomas Szasz would agree but would add that, as sentient moral agents involved in transactions with others, they are also responsible at least in part for the breakdown in communication and their subsequent difficulties.[iv]

A few pages after the explanatory note, Scull (1990) refers to some of the severely troubled individuals he is concerned with as "chronic schizophrenics" (p. 309). The use of that term usually indicates, at least in psychiatric literature, individuals who

are suffering from what is asserted to be a medical disorder, *schizophrenia* (APA, 2000). Is Scull, in his role as historian, using the term in the same way? His colleague Gerald Grob, based on his reading of Scull, contends that Scull "accepts the reality of mental disorders" as a medical issue (1994a, p. 274). For our part, we characterize Scull's view as ambivalent, since as far as we know he has published no explicit statement of his position on the matter, even while continuing to discuss "those afflicted with the most serious of mental ills" in his latest work (Scull, 2011, p. 124).

Even careful scholars who are generally critical thinkers have a tough time maintaining judgmental neutrality when it comes to inexplicable human behavior. They use terms in their works that have powerful medical connotations (e.g., chronic psychotics, schizophrenics, disease). This may be done by some authors in part to assuage their own anxieties because of the absence of scientific evidence for what is otherwise a congenial explanation of mad behavior. Medical language may be used by others to avoid implying any deliberate intention or moral agency on part of the "sufferers." On the other hand, a "method to madness" may be uncovered, when intention, moral purpose, and explicit goals for someone's "mad" behavior are revealed. Either effort involves situating the madman within his context and circumstances, explicating the madman's point of view, and the reactions of those around the madman and *their* points of view. This is historical work *par excellence* and of course is regularly attempted by most of the historians we discuss here. But when such work is attempted we think that—without medical language—it makes it extremely difficult to account for madness as *disease* and for psychiatry's development as a profession learning to identify and treat *diseases*. At least, this is what we argue in detail elsewhere (Kirk et al., 2013).

Finally, using medical connotations may be done to have one's work accepted for publication more easily.

One further complication lies in these historians' reticence to make explicit their own beliefs about madness. According to one younger historian, such reluctance may exist because "autobiography risks functioning as a 'subversive supplement' to the author's scholarship, in that it can expose personal commitments and experiences which undermine professional authority" (Engstrom, 2000, p. 423). The reluctance is completely understandable, but some textual exploration can easily identify the personal biases that, left unexamined and uncontrolled, may slant these histories toward a medical perspective. We turn to them presently.

Other Authorial Beliefs

Roy Porter in his *Brief History of Madness* claims that "the . . . historical survey [of madness] which follows . . . rests content with a brief, bold and unbiased account of its *history"* (2002, p. 4, italics in the original). The use of *unbiased* seems calculated to reassure readers that he produces narratives of historical facts as he finds them, with no worrisome distorting or unstated assumptions attached. But, in a publication written some twenty years prior, *Mind-Forg'd Manacles*, Porter admits that he "necessarily" makes assumptions regarding the nature of madness/insanity (1987b, p. 15). Madness, according to him, is best treated "like heart-failure . . . as a physical fact; but . . . interpret[ed] like witchcraft . . . principally as a socially constructed fact" (p. 15). Porter wants us to think of insanity both as a "personal disorder (with a kaleidoscope of causes, ranging from the organic to the psychosocial) and . . . [as] also articulated within a system of sociolinguistic signs and meanings" (p. 16). The labeling of insanity as "personal

disorder" is strictly Porter's own invention, and we cannot tell if by it he is referring to an organic disease (he offers no references in the text supporting the substance of his claims) or something else altogether.

Fortunately, we gain further insight regarding Porter's beliefs in a later, edited work, *A History of Clinical Psychiatry* (Berrios and Porter, 1995). Psychiatrist German Berrios and Porter address the issue of the organic bases of madness in their introductory chapter. They write that psychiatric historians can make useful contributions to clinical psychiatry by "building on the *belief* that mental disorders are complex and distorted reflections of dysfunctional brain sites and states" (p. xviii, emphasis added) in order to establish which past socially mediated descriptions of mad behavior can validly be mapped to certain abnormal biological processes and which cannot. So Porter does appear to believe that some madness has a physical basis and that history can help point out which behaviors were real biological illness and what "'psychiatric phenomena' were noise" (p. xviii). But this belief in the biological underpinnings of mad behavior is just that, a belief—as Porter is careful to state. Porter's amalgamated medical definition of madness as a condition resulting from brain and/or psychosocial abnormality and processed through a cultural and semantic filtering system is shared by most of our other historical sources.

Albert Deutsch presumes that mad behavior is mental disease, even if early man was lost in myth and magic to explain it. Originally published in 1937, his book *The Mentally Ill in America* (1967) consists of his distillation of much historical material through the medical sifter. As he asserts, "it is safe to assume that mental disease has always existed among mankind" (p. 2), and, "The conquest of schizophrenia . . . will

surely rank among the greatest of medical triumphs when it is accomplished" (p. 506). Deutsch never doubts the reality of mental disorder entities; he simply equates madness with mental disorder as he tells us that "[i]n early Greece, as in Egypt, mental disorders were looked upon as divine or demoniacal visitations" (p. 5). As the best example of mental disorder in ancient Greek mythology, Deutsch offers the inflicting of madness on Hercules by the goddess Hera. This problem, Deutsch claims, "[t]oday would be diagnosed as epileptic furor" (p. 6). Nonetheless, like every other historian of psychiatry, Deutsch also admits, despite his commitment to madness as disease, that "[a] mantle of mystery still hangs over a large area of mental disorder [although] . . . researchers . . . are striving manfully to tear apart this mantle, to bring light upon the nature of mental disease" (p. 518).

Another historian, Norman Dain, developed his classic book detailing the evolving historical *Concepts of Insanity in the United States* (1964) while working for three years as the research assistant to Eric T. Carlson, the associate attending psychiatrist at the Payne Whitney Psychiatric Clinic of New York Hospital. In it Dain states, "Of course even today no one understands the biology and chemistry of mental illness" (p. 207), but he never seems to question the appropriateness of assuming that the human problems he is describing are to be understood as mental illnesses, with relevant biology and chemistry. He regrets that most people still do not see that mad people are really "sick and helpless" (p. xii) and sees his job in *Concepts of Insanity* as explicating "the problems that confronted Americans in their early efforts to discard unscientific and unduly pessimistic attitudes and to place insanity under the aegis of medicine" (p. xii).

More recently, the Canadian historian Edward Shorter, among contemporary

psychiatric historians perhaps the most committed believer in psychiatric disorder as brain disease, was asked if he believed that "clinical depression" was an organic illness. He responded: "Yes, I believe depression is caused by some kind of brain process. It's a disease that is in a way just as organic as mumps or liver cancer" (Shorter, n. d.).This belief might direct his presentation of historical data since, in his often-cited book, *A History of Psychiatry,* Shorter states unequivocally that "[i]f there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry—treating mental illness as a genetically influenced disorder of brain chemistry—has been a smashing success" (1997, p. vii). Schizophrenia for him is also "a genetically influenced disease of brain development … there is no doubt that the disease is common, affecting perhaps one percent of the population" (1997, p. 61). Shorter's statements, of course, must be placed alongside sharply contradictory assessments of progress, even from within committed biological psychiatrists and the NIMH (see Kirk et al., 2013).

Shorter's uncritical commitment to the reality of biological causes of psychiatric disorders is further illustrated by his discussion in *A History of Psychiatry* concerning the increases in the frequency of "some kinds of psychiatric illnesses " during the nineteenth century, "in particular neurosyphilis, alcohol psychosis and . . . schizophrenia" (Shorter, 1997, p. 49). But neither of the first two is a psychiatric illness. Neurosyphilis is a neurological disease with behavioral correlates, a brain infection caused by the bacteria *Treponema pallidum*, if untreated leading to death. Alcohol psychosis is caused by toxic chemical poisoning: either too much alcohol consumption or sudden withdrawal from it. The historical record is clear that both these physiological disease processes, along with a

few others, were analogically applied by nineteenth-century mad-doctors to explain the phenomena they came to call schizophrenia (see especially Boyle, 2002). About the latter, some anonymous wit famously said that "unlike neurosyphilis it is a disease where the treating psychiatrists perish before the patients do." Shorter's silence concerning the hard empirical evidence for the physiological reality of the first two entities as diseases and the absence of such well-tested evidence for the "disease" of schizophrenia (though he lumps all three together as "psychiatric illnesses," can only be attributed, in our view, to political calculation, not historical or scientific judgment. What would be needed from him as an honest historical broker are the scientific facts regarding schizophrenia, both pro and contra, from the historical record rather than only presenting the neuroscience literature that supports his biological commitment to madness as brain disease (see his 1997, pp. 262-272). The current *DSM* states that "no laboratory findings have been identified that are diagnostic of Schizophrenia" (APA, 2000, p. 305). Of course Shorter knows this, as he explains in a later work when he concedes that "so little is understood about the underlying causes of psychiatric illness. Not having a solid 'pathophysiology' or understanding of the mechanisms of disease, psychiatry cannot rigorously delineate disease entities on the basis of anatomical pathology, as other medical fields do" (Shorter, 2005, p. 9). Yet, as we have seen, Shorter has stated that "clinical depression" is "just as organic as mumps or liver cancer" and schizophrenia is "a genetically influenced disease of brain development."

As previously identified, Gerald Grob is possibly the most well-known American psychiatric historian. In an extended footnote found in his 1983 book, *Mental Illness and American Society,* he argues forcefully that the psychiatric definition of *mental illness* is

not fundamentally different from the medical definition of *disease* (pp. 35–36). Grob implies that they are both appropriately subject to medical knowledge and medical authority. Yet, in the ultimate paragraph of that footnote he admits candidly:

> In fact, we know relatively little about what is designated as mental illness, and that makes it difficult to prove or disprove its existence. . . . Assertions about the existence or nonexistence of mental illness represent in large measure acts of faith which reflect commitments to a particular course or courses of action. (p. 36)

This fence-sitting allows Grob's early writings to be interpreted by his readers depending on their own individual predilections, while promoting his standing as an objective historian of mental illness.

In his 1998 presidential address delivered to the American Association for the History of Medicine, Grob states that "psychiatrists are compelled to deal with individuals whose pathologies are rarely clear cut and certainly never simple. Severe and persistent mental disorders—like cardiovascular, renal and other chronic degenerative disorders—require a judicious mix of medical and social support programs" (Grob, 1998, p. 213). This address is an apparently nuanced discussion of a type of difficult health problem. One could miss the use of perceptual rhetoric and metaphors (severe and persistent mental disorders—like cardiovascular disorders) to both define and frame his arguments. Although Grob knows that mental disorders are without any of the physiological markers of the biological diseases, he still analogizes the "severe and persistent mental disorders" to biological diseases.

This medical inclination may not have resulted from Grob's historical research

but rather from personal experiences. As he notes in his *Mental Illness and American Society*, "I would be less than honest if I did not speak of some personal views which undoubtedly influence my understandings of the past" (1983, p. xii). In preparation for the writing of his first psychiatric history, Grob attended Worcester State Hospital's training, provided to its psychiatric residents. This instructional opportunity allowed him to become familiar with clinical cases and institutional life at least as portrayed by those running the institution. He writes elsewhere that his experience "with severely and chronically mentally ill patients led me to reject many social control and deviance theories and reflexive anti-psychiatric thinking" (Grob, 1994a, p. 270). He admits that receiving instruction from psychiatrists at a mental hospital regarding patients "posed a risk of accepting conventional psychiatric claims at face value" (p. 270) but says that he was able to maintain at least partial distance from these beliefs. This is belied, however, by his use of conventional psychiatric labels to describe the inmates and their problems at Worcester State Hospital. It is worth noting that while Grob stated that he used his mental hospital experiences to accept the reality of "severe and persistent mental disorders" and to reject social control and deviance theories that might conflict with such an understanding, the sociologist Erving Goffman stated that he used similar experiences while conducting ethnographic research within St. Elizabeth's Hospital to develop the very theories that Grob rejected (Goffman, 1961).

In his later work Grob has more explicitly "come out" and committed himself to the mental illness as medical/brain disorder assumption and, further, has involved himself within the highly politicized process of federal health care policy. In a joint article on mental health policy, prominent academic psychiatrist Howard Goldman and Grob define

mental illness according to the US *Surgeon General's Report on Mental Health* (U.S. Department of Health and Human Services, 1999). Goldman and Grob (2006) quote part of that report as follows: "Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior . . . associated with distress and/or impaired functioning" (p. 738). The surgeon general's report adds that all diagnosable mental disorders are contained in the *Diagnostic and Statistical Manual of Mental Disorders IV* (1994) (*DSM-IV*), claims that they are all brain disorders, but recognizes clearly that no physiological markers are yet identified for any of them (1999, ch. 1).

Finally, Charles E. Rosenberg is an eminent medical historian who generally tends to be judicious in maintaining an agnostic perspective toward "the particularly ambiguous status of hypothetical ailments whose presenting symptoms are behavioral or emotional" (Rosenberg, 2006, p. 408). Nevertheless, in *Our Present Complaint* (2007), he states that "[m]ost of us would agree that there is some somatic mechanism or mechanisms . . . associated with grave and incapacitating psychoses" (p. 39). This statement commits him to a disease model based on biopathological mechanisms for at least these psychoses while being skeptical of the more general trend to medicalize other behavioral deviance (i.e., homosexuality, alcoholism, or hyperactivity—see his chapter 3). He neglects in this otherwise critical, thoughtful, and well-documented book to explain to readers why, lacking any current evidential support, grave and incapacitating psychoses, most probably schizophrenia would be one, should have such mechanisms attributed to them (see for example, Kupfer, First, and Regier, 2002, pp. xviii–xix).

Conclusion

Language is the filter through which public knowledge is communicated. The use of certain key words and not of others by recognized experts lubricates the expectations of audiences about how a social problem should be understood. The consistent use of medical labels like *mental illness, mental disorder,* and *mental disease* by historians of psychiatry as substitutes for the older descriptors *madness* or *insanity* tends to reify the view of madness as medical disease.

Many of these historians' semantic choices seem to be related to their personal belief or inclination that mental illness is a real medical entity or process. That belief confuses the replacement of an old metaphor by a new one with the progression from unscientific beliefs to scientific facts. Since, at best, the nature of madness is as yet unclear, we think it would be better if psychiatric historians would tell their stories by using more ontologically neutral terms, although we recognize the metaphorical nature of all language. These terms could include: *aggression, agitation, anguish, behavioral disorderliness, defiance, demoralization, derangement, distraction, hopelessness, sadness*, *severe emotionally distress, stress.* Historians should more closely endeavor, as many do, of course, to contextualize to the fullest extent possible the phenomena that they are attempting to describe by means of historical records. By using the most neutral terms possible in their narratives, without prejudging what has been discovered and scientifically established, historians would signal to their audiences that they are also groping, like other informed citizens, though they are giving us tools to come to our own deeper understandings.

The use of more neutral words would not and should not prevent historians from

presenting accurately and completely the views of all historically important figures, including those who propose(d) explanations and accounts of madness couched in medical terms and theories. We also think that historians' beliefs regarding what madness means or represents (that madness is mental illness or is not) should be declared or at least acknowledged. This would aid the interested reader by putting them on fair and proper notice about what may be shaping that historian's historical account, just as a believer in phlogiston should put readers on notice when presenting a history of physics, a believer in free market capitalism when presenting a history of communism, or a believer in the divinity of Jesus when presenting a history of Judaism.

Karl Popper (1989) argued that doing good scientific and intellectual work requires submitting one's most cherished paradigms and viewpoints to rigorous empirical tests and criticism to see if they stand up to such scrutiny because all human claims, hypotheses, theories, and beliefs are conjectural and subject to being wrong. This includes the work of the sincere archeologists of the historical past whom we have briefly examined in this article. As the historian E.J. Engstrom suggests, "the conceptual frameworks we have for thinking about mental anguish are (and likely always will be) woefully inadequate. That's what the history of psychiatry has taught me" (Personal communication, October, 9, 2008). Faced with woefully inadequate conceptual models to account for madness, the historian of madness, like any other person, might succumb to making common human errors, such as formulating inconsistent statements, ignoring discordant evidence, or failing to scrutinize one's assumptions. We have probably made some of these errors in this paper.

Our research suggests that all the historians (except Deutsch and Dain, who straightforwardly insist on madness being a medical disease) recognize through their scholarship both the critical (madness as word and as profound existential enigma) and the conventional (madness as medical disease) positions, but opt to couch their accounts in the conventional language. Why is that? Our guess is that to be considered a credible chronicler of the history of madness requires gaining the respect and the support of those people and institutions who exercise cultural, academic, political, and financial control over the contemporary domain of madness. As we have suggested here and argue more comprehensively elsewhere (Kirk et al., 2013), in order for historians to be considered legitimate scholars they must infuse, at a minimum by the use of medical jargon, the reigning psychiatric-medical disease model of madness into even the "objective" descriptions of the history of madness.

We conclude that the determination of historical facts is a fallible process, depending on a particular historian's personal beliefs, agenda, and decisions regarding what words to use and what evidence to attend to and to ignore in constructing a narrative. This is especially so about phenomena for which the meaning of most descriptors is variable and contested. So, *caveat emptor*.

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Notes

[i] We tend to agree with Thomas Szasz that the better term for the coercive paternalistic approach accepted by most psychiatrists is the pediatric model, since typically other physicians treat adults who seek their services. Only pediatricians and psychiatrists treat persons who do not seek their services. Pediatricians treat children often against their but not their parents' will because by law children cannot make independent decisions about their welfare, while psychiatrists by law can treat adults against their will by dealing with them as if they where irresponsible children (Szasz, 1987, p. 91).

[ii] This is similar to the term *behavioral health*, whose use in the medical and psychological literature first appeared in the 1970s and dramatically spiked starting in the mid-1990s (see, for example, Google's ngram using this term). This obvious metaphor appears well-suited for its primary purposes, as far as we can discern them at present: to justify both the increased involvement of psychologists and social workers in the health care arena and the increased and renewed involvement of physicians in changing patients' behaviors.

[iii] This begs the question of what in the "center" of madness, as opposed to its margins, is invariable and unambiguous.

[iv] Szasz—described by Micale and Porter in their edited volume *Discovering the History of Psychiatry* (1994) as "offer[ing] fundamental rereadings of exemplary episodes and topics in the history of mental medicine" (p. 23) worthy of a full chapter in that book—has never asserted what Scull (1993) and many other of his critics claim to be Szasz's position, namely, that mental alienation is merely the result of social labeling and scapegoating and is a myth. Szasz argues that emotional difficulties and tragedies are real, but result from the minor and serious problems that people experience while trying to make a life, rather than the consequence of biological pathology. He suggested that "[t]o regard 'minor' upheavals in living as problems in human relations, learning and so forth—and more 'major' upheavals as due to brain disease, seems to be a rather simple example of wishful thinking" (Szasz, 1961, p. 94). In his first and most often cited but rarely fully understood classic, the *Myth of Mental Illness* (1961), Szasz did not write a polemic full of simplistic claims as Scull asserts (2011, p. 100), but rather a detailed and scholarly treatise outlining, as its subtitle states, the "foundations of a theory of personal conduct." Using a combination of semiotic, rule-following, and game-model analysis, Szasz proposes a theory of human behavior applicable to both the "normal" and "deviant."