

“We’re All Mad Here”: Power and Identity in the Modern Era of Mental Illness

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Abstract

Mental illness is the modern term for the classification of conditions originally referred to as madness prior to The Enlightenment. Before the Enlightenment, madness was identifiable by the outwardly deviant behavior of individuals acting out of unreason. This definition manifested in the absence of expert knowledge or organized efforts to study the nature of the condition. During this time, madness was seen as a condition of divine origins with the afflicted being blameless. This perception changed during the Enlightenment when madness became associated with moral error. This perception caused the widespread isolation of the mad from the general public. Confinement indirectly catalyzed the study of madness as a condition because it isolated the afflicted into a setting where they could be independently observed. This study spurred the development of systems that classified specific mental illnesses based on symptoms, thereby officially labeling madness as an illness. As advances in the field of psychology have led to an increased number of recognized conditions, modern diagnostic systems can diagnose any individual with a form of mental illness. While this broad system contains the ability to extend care to any who may benefit from it, stigmas associated with mental illness can restrict the social power of diagnosed individuals. To combat stigma and extend treatment opportunities to a wider population of need, a system that recognizes each individual as existing on a continuum of mental wellness must be adopted. Current systems dichotomize mental health and mental illness in a manner that ascribes an identity to the diagnosed and restricts their societal power. By recognizing conditions as often transient in nature and existing within a continuum, publics can empower the mentally ill while providing psychiatric care to those who would typically not receive its benefits.

Introduction

Narrenschiff: the ship of fools. This phrase is typically remembered as a literary trope today, but in the twelfth century this concept had a tangible counterpart. Towns, which were unable to treat the mentally ill, would round up the mentally ill and load them onto vessels before unceremoniously shipping them downstream. An unwanted cargo unable to provide for themselves, these people floated on from settlement to settlement. Each town would awaken to a new shipment of madmen and provide for them until their deviant behavior became problematic, and then the cycle would repeat. Eventually the river stopped, and, with it, the ship of fools ended its long journey. Cities at the end of rivers became known as pilgrimage sites for the insane. These locations served as the terminus in a curative journey for those who could not be cured.

The ship of fools may seem cruel by modern standards, yet its present-day analog persists. “Grey Hound Therapy,” in which problematic mental-health patients are discretely loaded onto buses with a one-way ticket to the next town, is a practice that was developed in the nineteen-sixties which continues to exist today. In 2014, one facility was charged for shipping almost two thousand patients to adjacent states without adequate provisions of food, housing, medication, or medical care (Rather, 2014). Despite advances in our understanding of the mind and its ailments, prejudice and stigma continue to define the relationship between publics and their mentally ill sub-populations.

What was simply madness in the time of the *Narrenschiff* has been subdivided into several distinct illnesses. Schizophrenia is rarely mistaken for obsessive compulsive disorder and both share almost no symptoms with epilepsy. Yet it is only within the last one hundred years that these illnesses would be classified as anything other than madness. Until this time, the behavior brought on by illnesses of the mind was simply considered deviant, incurable, and mysterious.

The twentieth century, with these distinctions created, brought the era of what was called “heroic” therapies. Among these, electroconvulsive therapy and the lobotomy offered something that had never been observed before: a scientific method of altering both mind and behavior.

These technological advances shattered the illusion that the mind was divine and unable to be understood. While they may be seen as crude instruments of the past, the lobotomy hammer and the shackles used in electroconvulsive therapy define the identity of the mad population today. While the deviant behavior of the mentally ill had defined only their social class, now science could interact with the mad through these tools. For the first time, madness could be observed and altered. This began the modern era of mental healthcare, the first foray into curing madness.

Since this time, madness has been split into a multitude of conditions. Some of these have acquired treatments capable of restoring their population’s behaviors to societal norms. Others have remained misunderstood and defined by stigma. If these conditions share a common

origin in madness, how have some escaped prejudices while others have not? What has caused publics to adopt some of their mentally ill sub-populations without question while treating others with contempt and discrimination? In the present era, we find ourselves at a crossroads uniquely poised to examine madness in a historical context and address some of these questions.

This text examines the historical events that led to the development of our current medical definitions of mental illness and how these systematic definitions have failed to accurately describe conditions of the mind as stemming from tangible, physical disruptions to the brain. Definitions of mental conditions were instead based on degrees of deviant behavior, a practice developed by a scientific community that lacked the tools to accurately examine the functions of the mind. The result of these inaccurate definitions has been a general belief that one is either mentally ill or normal when mental illness instead falls into a continuum and likely affects the entire population in both chronic and temporary manners.

Madness

Historian and social theorist Michel Foucault notes in his text *Madness and Civilization: a History of Insanity in an Age of Reason* that distinction between forms of mental illness was virtually nonexistent prior to the 18th century (Foucault, 1965). Madness was utilized as a term to describe all manner of mental afflictions ranging from seizures to hallucinations. The behaviors and mannerisms of those who suffered from madness clearly did not align with societal norms, yet they could not be adequately explained by science nor understood by others. In the absence of experimental knowledge, a variety of explanations for the origins of madness arose. For instance, Hippocrates proposed a theory aligned with the commonly held belief of bodily “humors” stating that an excess of black bile would induce irrational thoughts and actions (Weinstein, 2007). Other cultures attributed seizures and talking to oneself to signs of demonic possession. Regardless of the proposed explanation, madness was considered a state that could be neither induced nor cured and was characterized entirely by deviant behavior. Foucault’s analysis of social powers in the modern era has proven influential in the academic setting and provides a framework for the examination of how historical definitions of madness may have protected mentally ill publics from forms of oppression (Antliff, 2007).

Even in the absence of rigorous scientific understanding of madness, the mentally afflicted existed as a largely integrated subculture in most publics (Foucault, 1965). Early documents from the Roman Empire indicate that not only was humane treatment of the mad encouraged, the Romans even codified the mitigation of responsibility for criminal acts committed by the insane into law (Robinson, 1995). Michel Foucault notes that while lepers and those suffering from plague were cast out of cities, the mad were largely left undisturbed (1965). While some have pointed out that poor treatment of the mad was commonplace in several early

European publics, such as the Narrenschiff, it appears the insane were regarded in a similar manner to other low social classes. As long as their deviant behaviors did not bring harm to the general populace, the mad remained an unexplainable phenomenon conflicting with societal norms that was rarely persecuted.

Although the mentally afflicted in this era may have been subject to discrimination like that faced by the poor and slaves, they were not isolated from mainstream society. Rather, the mad lived within city walls and were integrated with other social classes, separate yet still present. The behaviors of the mad labeled them as deviant and they were mysterious enough to be considered as only explainable by divine forces. Even Hippocrates' largely secular theory of black bile could neither be tested nor controlled. This inability to explain the behaviors of the mad led to an association between the mad and the Divine. In Renaissance art, Foucault notes that the mad were portrayed as possessing a form of wisdom beyond that of the natural world. Classical art and literature likewise depicted the mad as possessing knowledge unattainable to mortals. Despite the apparent reverence for the mad conveyed by this interpretation, these portrayals marked an objective distinction between reason and unreason as defined from outside of society. Over time, this distinction would grow to define the mad as not just deviant, but counter to cultural norms. This would eventually result in the isolation of the insane from mainstream society (Foucault, 1965).

The founder of the field of postcolonial studies, Edward Said, was an avid critic of the means by which Western publics perceived and romanticized the Orient. The depiction of the mad in Renaissance art and their ultimate rejection of by Western publics mirrors this Orientalism. Said noted that western artists and writers would depict the Middle East as static, undeveloped, and lost in time (Said, 1979). Over time, the falsified depiction of these cultures became accepted and reproduced, thereby propagating the idea that western society was superior to these foreign lands. Orientalism creates a system wherein the depicted publics cannot define their own identity and are thereby subject to sweeping generalizations. Similarly, the mad were depicted as mysterious and counter to this world in art, cementing the notion that the rational were natural and superior. Unable to speak for themselves or define their own identity and without any scientific understanding of mental illness, the mad were subject to these depictions classifying their condition.

The Great Confinement

Although the mad were labeled by their deviant behavior, for most of recorded history they were not considered ill or in need of treatment. The construction of insanity as an illness did not occur until madness came into conflict with the values of Western culture during The Enlightenment. At the turn of the 18th century, the West adopted a philosophy that revered logic, reason, and progress. These values conflicted directly with the

behaviors of the mad. Thus, the mad were seen to suffer from moral error having chosen unreason over logic. In the eyes of Western publics, the insane ran counter to progress and were unable to contribute. This left no room for the madmen, resulting in their isolation from the general public.

A number of social forces resulting from the counter-culture behaviors of the mad drove Western publics towards confinement as a solution. Within these forces, a desire to regulate unemployment and create productive society was very common. Since the mad were seen as having freely chosen to disrupt society, they were considered similar to criminals, and they were treated as such. In the Age of Reason, the mad were seen not as a mystery but as a danger for the first time.

This era was marked by a rapid proliferation in the number of asylums for the insane. Patients were generally admitted without their consent when the local public or their families deemed them problematic. Those who were considered violent or especially disturbed would be chained, but other inmates were free to wander within the confines of these asylums (Andrews, Briggs, Porter, Tucker, & Waddington, 2013). Foucault notes this movement as a radical shift in the treatment of the mad, referring to it as “The Great Confinement” (1965). The sudden rejection of the insane by the publics and the lack of a centralized response from Western governments meant that private asylums quickly expanded. Surprisingly, this rejection and confinement of the mad by society directly led to the treatment of mental illness as we know it in the modern era.

The Great Confinement resulted in, for the first time, isolated and observable populations of the mentally ill. This meant that their abnormal behaviors could be studied in a scientific manner. King George III's high-profile mental illness further catalyzed scientific inquiry into the behaviors of the mad (King, 1971). Undergoing remission in the late 18th century, the monarch represented a well-known case of madness acting not as a mysterious force or moral error, but as an illness that could be treated and cured. This case caused a shift in the scientific community's relationship with mental illness. With a conveniently isolated population of mentally insane subjects, doctors and scientists turned towards asylums and for the first time, approached madness with medicine and scientific method.

With madness having been declassified as a divine force during the Enlightenment and now defined as an illness by Western publics, the stage was set for the modern era of mental health to begin. While the initial goal of confining the mad from the general public was to reduce the impact of their deviant behavior, a newfound desire to cure the mad in a location away from their families or others who could not afford the necessary care at home began to emerge. Doctors and scientists now saw mental illness as a condition that, while still mysterious, shared characteristics with sicknesses of the body. This meant that the definition of mental illness was now dependent on what those studying it could physically observe, and this was in turn dependent on the tools available to researchers.

Through early history until the Enlightenment, madness had been

considered as a divine force. The mad were not seen as at fault for their condition, but rather the passive recipients of an unfortunate and mysterious affliction. With the dawn of an Age of Reason, this reasoning changed. Consequently, the mad were confined, locked away, and studied. This is where the first attempts to manipulate and cure the mind occurred. Furthermore, this time is when the identity of the mentally ill became inexorably tied to the technological artifacts available to researchers for curing these illnesses.

Technological Artifacts and the Construction of Illness

To understand illness—especially mental illness—as a social construct, it is useful for one to apply a distinction between disease as a biological condition and illness as a social identity tied to the manifestation of that condition (Eisenberg, 1977). While this approach has its limitations, the advantage of understanding illness as the interface between publics and disease is that it illuminates the fact that the identity of the ill is tied not to the disease's physiological cause, but what can be observed (Conrad & Barker, 2010). Furthermore, a multitude of distinct underlying physiological conditions could result in the same apparent illness. For example, Acute Bronchitis and Lung Cancer each manifest in bouts of coughing, chest pain, and fever, yet their causes are entirely different. Without the proper tools to distinguish between the underlying diseases, the outward illness would be the same to the general publics. Similarly, the condition of madness acted as a blanket term for a multitude of diseases causing the afflicted to act "unreasonably." The social construction of mental illness results in two key phenomena: the mentally ill have their identity determined entirely by non-ill publics and that these identities are based entirely on what the public can observe about the mentally ill.

Modern researchers have noted the ways in which the identity ascribed by the publics to the mentally ill has consequences on their behavior and political power (Conrad & Barker, 2010; Freidson, 1970). These effects compound the physiological disease with further social implications. For instance, the Great Confinement was born out of the ascription of identity and its resulting imbalance of power between the mad and normal publics. The mad could be isolated from mainstream society like criminals because they had no direct ability to alter the identity given to them by the sane publics. Yet, once the mad were in a setting where they could be studied by medical professionals, mental illness became the subject of medical discourse between experts. Expert knowledge about human "normality" and "abnormality" is a key form of power in modern society as it directly controls the identity and influence of affected publics (Foucault, 1965). By isolating the mentally ill from sane publics, The Great Confinement had the effect of shifting the power of ascription from sane publics to experts in the field of medicine. The same principles of social construction continued to apply in this setting.

Mental illness was defined by what these experts could observe directly. These observations were in turn dependent on the tools available to researchers.

Whereas the sane public constructed an identity for the mad based on normative standards for behavior, experts in the then emerging field of psychology utilized scientific process to obtain knowledge. One of the first areas of study was the comparison of mad individuals between each other, marking the birth of many distinct disorders from what had previously been described simply as madness. As psychology gained widespread practice, systems for the categorization and definition of mental illnesses solidified. These systems were necessary for researchers to hold scientific discourse on the topic of mental disorders. However, they marked a pivotal transfer of power regarding the ascription of the normal and abnormal identities. Diagnostic manuals were the manifestation of the normative standards first employed by the general public and then experts. While these artifacts allowed experts to communicate and research in a standardized fashion, they often utilized broad generalizations to categorize specific disorders.

Emil Kraepelin designed the first classification system to gain widespread popularity in the early twentieth century. Reflecting a growing movement to classify disorders as mental illnesses and redefine asylum inmates as patients, Kraepelin's classification system was constructed with the intention of applying a clinical approach, instead of previous symptomatic methodologies, to the definitions of mental illness. Whereas prior methods of diagnosis had classified illness based on the most prevalent symptoms at a given moment, Kraepelin's approach focused on recurring patterns of symptoms. This system quickly gained popularity and led to the separation of mood disorders and schizophrenia. However, even Kraepelin's classification system relied on vague generalizations. Although it was widely accepted among experts at this time that psychiatric conditions had underlying genetic and physiological causes, these causes could not be observed directly with the technology available. Diagnostic manuals such as those designed by Kraepelin allowed mental illness to become a matter of medical and scientific discourse, yet they failed to encapsulate the physical conditions underlying the illness. These systems of general definitions caused high comorbidity between conditions as well as the possibility of diagnosing almost any individual with a form of mental illness. The prior system of isolation remained even as inmates were labeled as patients and asylums were labeled as hospitals. The mentally ill were still often confined against their will and had their identity ascribed to them by artifacts in the form of classification systems.

In the absence of methods to treat the underlying cause of mental illnesses, mental hygiene grew in popularity to prevent insanity as a disease. Being identified as mentally ill had drastic consequences at this time. Beyond forced confinement, many patients in the United States were sterilized as part of the eugenics movement. In addition, over two hundred

thousand patients were put to death in Nazi Germany. These social efforts to cure mental illness via the extermination of the insane only fed into the system of stigma that limited the power of the insane publics. Even today these atrocities receive little attention in the scope of history.

A system had been created where the insane were perceived as an incurable threat to the progression of society, and a system of isolation that resembled imprisonment only reinforced this perception. Sane publics interacted with the mentally ill through these policies, which only confirmed their identity as deviant and dangerous individuals.

The Western publics entered the modern era of mental healthcare with the first attempts to “cure” conditions of the mind in the early twenty-first century (Foucault, 1965). Retrospectively, these methods appear exceedingly cruel and barbaric. However, the portrayal of the mentally ill as threatening made these techniques seem almost humanitarian at the time. An excellent example of this is psychosurgery, specifically the lobotomy. Lobotomy rapidly gained popularity as a procedure in the mid twentieth century. The procedure required the doctor to insert a specialized pick into the frontal lobe of the patient by pushing it past the side of the eyeball. Once inserted, the tool was manipulated to damage the brain tissue. After being repeated on each side, patients typically demonstrated a severe loss of their ability to process emotion. These results immediately drew criticism from the scientific community, with many denouncing the procedure as dangerous and barbaric. Reports of patients becoming incapacitated or fatally injured were widespread, yet lobotomy continued to gain popularity, especially in the United States. Between 1940 and 1950, nearly twenty thousand lobotomies were conducted. This surging popularity can be attributed to the fact that lobotomy represented the first successful “cure” for madness. The procedure left individuals with clear and recognizable cognitive limitations, but the altered behavior more clearly aligned with normative standards than did madness.

Lobotomy demonstrates a pattern of mental health treatments based on the assumption that restoring "normal" behavior outweighs the risks of such treatments. This procedure was performed with several variations in order to treat conditions ranging from schizophrenia to manic depressive disorder, syndromes which encapsulate a variety of symptomatic patterns. While a small percentage of patients could be considered sane after the treatment, many more were left with significantly reduced intellect. This mental dullness would commonly strip patients of their personality and sometimes leave them unable to live independently. These consequences were judged as secondary to the potential to cure mental disorders.

Psychosurgery fell out of popularity in the 1950s as antipsychotic drugs gained popularity as a seemingly less invasive and more effective treatment. Even as pharmaceuticals remain the most popular form of treatment for mental disorders in the United States, the implicit assumption that the restoration of normal behavior outweighs any possible

risks persists.

These treatment artifacts are constructed on a binary system that assigns an identity of mentally ill or healthy. With the physiological causes of many mental illnesses still unknown, state of the art medicine treats symptoms rather than the underlying disease. Despite a seemingly enlightened approach to mental healthcare in the modern era, our systems and artifacts bear an eerie resemblance to those that were established during the height of prejudice towards the insane. Foucault argues that modern forms of treatment are no less cruel or restrictive than they were before:

There is no common language: or rather, it no longer exists; the constitution of madness as mental illness, at the end of the eighteenth century, bears witness to a rupture in a dialogue, gives the separation as already enacted, and expels from the memory all those imperfect words, of no fixed syntax, spoken falteringly, in which the exchange between madness and reason was carried out. The language of psychiatry, which is a monologue by reason about madness, could only have come into existence in such a silence. (Foucault, 1965)

This grim assessment still rings true in that the mentally ill in many cases still have their identity ascribed to them and their power restricted. Mental health has become a matter of medical discourse between experts that reflects priorities in restoring normal outward behavior despite disruptive yet less apparent effects. Artifacts such as the DSM (Diagnostic and Statistics Manual of Mental Disorders) utilize broad generalizations to categorize individuals as healthy or ill in a binary manner. The flaws in these artifacts reflect a neopositivist system with ambiguous boundaries and high co-morbidity (Aragona, 2009). These diagnoses in turn have the potential to significantly limit an individual's power and ascribe an identity that carries prejudice and stigma.

As the consequences of this diagnostic process have become clear, the mentally ill public is beginning to coalesce around efforts to increase their societal power. Patients diagnosed with mood disorders, particularly major depressive disorder (MDD), appear to be at the center of a movement away from a binary system of categorizing mental illness and mental health. This movement has the potential to mitigate stigma and increase the power of not only mood disorder patients but all mentally ill public.

A Novel View of Mental Wellness

A binary system that defines mental normality and mental illness as two distinct states of being has held fast since the diagnosis system was created during The Great Confinement. This system holds the capability to perpetuate stigma and prejudice through the othering of the mentally ill. Furthermore, it causes a diagnosis of the mind to carry immense weight capable of altering an individual's identity and power. Many systems are designed with intrinsic discrimination against mentally ill individuals. In professional settings, individuals suffering from major depressive disorder

may be viewed as unmotivated or unproductive. More extreme examples include the homeless population, a substantial portion of which suffers from severe psychological illness (“NAMI: National Alliance on Mental Illness | Mental Health By the Numbers,” n.d.). While even moderate forms of mental illness can diminish an individual’s capability to meet the implicit standards of productivity, motivation, and reason, severe illnesses can entirely negate one’s capabilities to seek employment or lead what would be judged as a normal life. Despite the apparent advancement of care, prejudice is still omnipresent in the design of systems and it continues to limit the opportunities of mentally ill publics.

Discrimination against the mentally ill is gaining more widespread attention in Western publics due in part to the rising number of diagnosed individuals. Last year, it was estimated that one quarter of the adult population experiences a form of mental illness with most of these conditions beginning in teenage years (National Institute of Health, 2015). Severe mental illnesses, a category that encompasses schizophrenia and more dramatic symptoms, occur in approximately one in seventeen adults. Accordingly, recent additions of the DSM, the modern standard for the diagnosis of mental conditions, have contained diagnostic criteria for an increasing number of conditions.

The creep of psychological diagnosis is quickly turning the mad minority into a majority. Psychologists have remarked that nearly anybody could be diagnosed with a form of mental illness as defined by the DSM-V (“Now You Too Can Be Diagnosed With Schizophrenia!,” n.d.). Contrary to what could be assumed, the increased capability of artifacts such as the DSM to ascribe identity to individuals displaying less apparently abnormal behavior has not seemed to mitigate the power of such a diagnosis.

Beyond this, experts have surpassed reliance on these diagnoses as rigid definitions encompassing expected behavior and most effective treatment methods and have used them to fill niche rolls ingrained in the medical system. For example, a psychiatrist believing that anti-anxiety medication will aid a patient’s quality of life may not believe that the individual truly suffers from a panic disorder. However, they can provide that patient with reimbursement for medication if a diagnosis is provided and entered into the healthcare system (Pierre, 2014). In this case, the expert has ruled that patient is not ill but would benefit from medication. This nuance is not captured by the design of the healthcare system however, so the expert then must provide a diagnosis of mental illness to give the patient treatment. Because of this, the patient is handed a diagnosis and provided with medication. Yet, it should be noted that this diagnosis still impacts the individual’s self-image and standing in society. The diagnosis still carries the label of abnormal, and the medication provided is designed with the assumption that the effect of mitigating anxiety is a priority over any “side effects.”

Examples such as this show the changing role of the mental health

professional. Where they were once seen as medical experts studying the confined mad, the view that their methods may benefit many beyond the apparently ill has propagated over time. Not only has the field of psychiatry given birth to an array of professions ranging from social workers to psychiatrists, the mentally ill have been categorized based on severity of symptoms from severely ill to the “worried well” who may simply demonstrate moderately abnormal behavior. The broadening role of the psychiatrists coupled with the expanding population of the mentally ill have each been driven by the limitations of the binary system of mental illness and wellness. This system was born out of a time before The Great Confinement when madness was not a matter of expert discourse, but was a consensus among mainstream publics as to who behaved reasonably and who acted out of unreason. Confinement made madness a matter of expert knowledge, but still carried with it the assumption of a clear distinction between the normal and abnormal mind. Yet this surrender of prescriptive powers to experts caused a schism to occur. As psychiatry progressed, previously unknown conditions were discovered and the truth that we all are, in effect, suffering from a multitude of conditions was slowly revealed. The initial distinction between madness and reason, however, was never disposed of. Therefore, psychology now treats both those who are incapable of living independently due to the severity of their condition as well as those who display little to no outward symptoms. This broad spectrum of conditions is still referred to as mental illness and all who fall into it are ascribed a monolithic identity that carries with it the weight of stigma and prejudice.

The advancement of artifacts intended to restore normal behavior has coupled the increased ability to diagnose less apparent disorders with the enhanced ability to treat such conditions. Medication to quell anxiety and extreme moods is increasingly prevalent despite the attached stigmas and often reported reluctance of individuals to receive such drugs. Whereas early artifacts such as psychosurgery tools or the first generation of antipsychotics treated dramatic symptoms with dramatic results, current drugs can make minor changes to the mood with little to no outwardly apparent effects.

While historic methods bear the guise of being barbaric and cruel, it is worth considering how current methods will be viewed by future generations. With the diseases underlying mental conditions still largely unknown, these methods still treat only the socially constructed illness. They carry with them the assumption that the patient is the problem, they are the abnormal one in a system of normality. Their side effects imply that restoration of normal behavior is worth other disruptions to wellbeing.

With an increased ability to diagnose and curb psychological systems, the mentally ill minority has grown rapidly and will continue to grow. This has driven increased advocacy for the mitigation of stigma and the provision of care for especially the severely ill. Whereas the severely mad who were the first to be confined could not achieve a reasonable dialogue

in their own defense, the expansion of diagnosis to patients who display few outward signs of mental illness has increased advocacy from the mentally ill themselves. Experts in the field of mental health have also advocated for policies that defend against discrimination and have further highlighted the limitations of DSM based diagnoses (Aragano, 2009).

Both the social recognition of discrimination and dissatisfaction of experts with the ambiguity of diagnostic manuals have driven a growing movement away from the binary system of viewing mental illness and towards a view that recognizes mental wellness as a fluid continuum on which every individual exists (Pierre, 2014). This system of understanding mental health would still include those who cannot provide for themselves due to the severity of their condition as well as allowing for the recognition that any individual has the potential to benefit from psychiatric practices at a given point in their life. Given its apparent capability to mitigate stigma and encourage the acceptability of seeking help for potentially dangerous emotional states, this system appears to offer significant societal benefits.

To create a system in which every individual can be recognized to have the potential of benefitting from mental treatment, mental conditions must be seen not only as varying in severity, but transient in nature. The public has historically resisted this approach, placing emphasis on severe and permanent conditions (“What If We All Got Mentally Ill Sometimes?,” n.d.). This resistance is to be expected in that historic systems of diagnosing and treating mental illness were focused on permanent, severe conditions. Furthermore, many have expressed concerns about the over-prescription of medication for emotional and mental conditions (“Overprescribing Antidepressants,” n.d.). Indeed, the growing popularity of antidepressants has caused outcry from those who point out that many people receiving antidepressant treatments cannot be reliably diagnosed with a mood disorder. While it could be that the “worried-well” population receives only marginal benefits from prescriptions, many who receive a prescription could be experiencing a transient period of what could be classified as mental illness. It should be noted that many mental illnesses are classified specifically by duration of recurring symptoms, but a number of patients could nonetheless benefit from treatment during temporary periods of extreme symptoms. This system of medicine more closely mirrors physical medicine where it is normal for a patient to receive pain medication while recovering from an injury. By viewing mental health and wellness as a continuum on which every individual shifts, we not only allow for a wider population to benefit from psychiatric treatment, but we can more effectively observe the transient nature of some conditions.

A continuous view of mental wellness is reflective of a reality in which we still do not fully understand the underlying causes of psychiatric symptoms. It should be considered that advances in key technological artifacts such as magnetic resonance imaging and advance gene screening

techniques may in fact allow for a future in which the disease is fully understood. This would create the potential to bypass the social construction of illness and allow for publics to interact directly with the disease itself. Perhaps this interaction would mitigate stigma by shifting implicit blame of one's condition from their own error to the underlying physiological cause. Prior to the Enlightenment, the madman was not seen as responsible for his conditions and was therefore remarkably well provided for. It is reasonable to expect that the same social conditions may take hold if technological artifacts can illuminate the diseases underlying mental illnesses. Barring this form of technological advancement, the power to shift the public perception of mental illness rests largely with experts.

Both expert researchers and many of the diagnosed public have coalesced around a movement to reform the DSM guidelines (Coalition for DSM-V Reform, 2012). However, these groups typically cite diagnostic ambiguity and the capability to provide "false positive" diagnoses as the primary issue with the artifact. Proposed reforms would narrow the criteria of diagnosis and reduce co-morbidity of conditions. This reform could more clearly separate the severely ill from those who demonstrate mostly normal behavior, but it would further perpetuate a binary system of normality and abnormality and increase stigma.

For an effective system of understanding mental health to gain mainstream traction, it seems that experts must move past the concept of normality and promote the notion that even the seemingly healthy may benefit from the techniques of a psychiatrist. As mental illness has become a matter of medical discourse, medical experts and the artifacts that they have constructed appear to be the only actors with the power to shift the binary conception of madness born out of The Great Confinement. Yet even diagnostic artifacts such as the DSM are designed with this view of normality and abnormality. Without a publicized movement from experts aiming to change the general conception of mental illness as well as discriminatory practices and policies, the mentally ill may well continue to suffer from a system that is designed to punish them for conditions over which they have no control.

Conclusion

The history of madness paints a picture in which the madman has had their identity ascribed by varying parties over time. Prior to the Enlightenment, he was afflicted by the gods and therefore a helpless victim. As The Great Confinement spread across the western world, the madman was seen as having chosen unreason. Then, the madman existed as a danger to society. It was this very confinement that allowed the mad to be studied, thus making them subjects in a matter of global scientific discourse. Yet it was only in the modern era that the madman was seen as an ill patient, one whose condition was diagnosed by one set of artifacts and could be treated by another.

Despite this tragic history, our modern view of the madman may not be as bleak as Foucault suggests. Recognition of the limits of diagnostic guidelines is gaining widespread attention and the mentally ill are driving a movement against stigma and prejudice. The mad are re-entering mainstream society as even the outwardly invisible ailments are categorized as mental illness. Yet this movement out of confinement has not yet dispelled the outdated methods of understanding the madman. We promote a view of the world in which the individual controls their motivations and thoughts, while the very opposite is largely true. Half of the population will experience a panic attack during their life. Their heart will race and their body will collapse as they find themselves completely at the mercy of a psychiatric experience they never expected to have. A third of the world will find themselves in the grips of severe depression, unable to motivate or find joy in a system that demands they be productive each day. One in twenty individuals will consider suicide, often blaming themselves for the guilt and despair that they feel (National Institute of Health and Medicine, 2010).

Perhaps it is because our systems impose chronic stress and demand normality that mental abnormality exists in each of us. The expectation that we can achieve mastery of our emotions and approach each task with motivation and joy renders all of us abnormal, even if it is not apparent in our outward symptoms. A view of mental illness that dichotomizes the spectrum of emotional wellbeing into simply illness and health is a relic of an era where the insane were criminals and a threat to societal progression. It is time for an open dialogue on mental wellness to begin, one where we can admit that we are all a bit mad.

The definition of mental illness has existed in flux largely due to its lack of a physiological condition to provide it with a universal context. To account for this, the definition and study of mental illness has largely become a matter of expert discourse. These experts have recognized the current limitations of their diagnostic systems, but movements from these parties have generally pushed for more rigid diagnostic criteria with a focus on severity and permanence of condition. While this focus may legitimize the diagnostic process to a certain extent, it fails to provide aid to a vast population who could benefit from temporary or low-intensity treatment. To account for both the transient nature of mental conditions and the fact that truly anybody could benefit from psychiatric treatment at some point in their life, a spectral view of mental health and illness must be adopted. This perspective dispels the notion that mental health and illness exist in dichotomy and recognizes the reality that we may all experience periods of depression, anxiety, or suicidal ideation. Acceptance of these conditions as normal in that we are all vulnerable to them not only combats stigma, it encourages those who would otherwise suffer without aid for fear of admitting their illness.

An altered perspective on mental health also must be reflected in our systems of treatment. Rather than a focus on the restoration of normal

behavior, an individual's quality of life must be thoroughly considered in choosing a treatment plan. Without the capability to treat the underlying disease, it is largely the outward symptoms of mental illness that medicine has come to focus on. Medication for treating an individual's attention deficit is constructed with the implicit assumption that focus is valuable enough to justify the increase in anxiety and nausea that they may experience. Since the lobotomy, our artifacts for the treatment of mental illness have consistently reflected a desire to restore normal behavior. To truly improve their quality of life, however, a dialogue must be established between the patient and the practitioner in which the two can consider not only symptoms that manifest as abnormal behavior, but what the patient hopes to achieve through treatment.

While the diagnostic process for mental illness was handed over to experts during The Great Confinement, the diagnostic creep of psychology coupled with the enhanced abilities of individuals to generate a public following through social media outlets interestingly shifted power to the mentally ill population. The growing population of individuals with a mental diagnosis coupled with the ability to use social media as a platform for advocacy has caused campaigns against stigmas associated with mental illness to gain momentum. These movements represent a historical transfer of power to mentally ill publics. As more individuals receive diagnoses from mental health professionals, these movements will presumably only continue to gain momentum. This is evident in the focus on mental health in recent political and research efforts. These movements hold vast potential in combating stigma and allocating power to the mentally ill. However, the dichotomized view of mental illness and wellness will continue to subject the mentally ill to societal othering as long as it exists. The current understanding of normal behavior fails to encapsulate the nuanced nature of the mind and its conditions. Until a perspective that recognizes everyone as having the potential to benefit from psychiatric care gains widespread acceptance, stigmas against those with severe symptoms will persist while those with transient and minor symptoms will fail to receive the benefits of psychiatric care.

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