

Madness as Disability

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With interest in mental illness from the standpoint of the growing field of Disability Studies comes a problem for the Medical Humanities.¹ Is it possible to discuss what may well be the most stigmatizing form of illness or disability in the West without understanding the complexity of the tradition in which it stands? The diagnostic history of mental illness is entangled with the history of madness as a social convention, a history that colors even the contemporary debates about the meanings and forms of mental illness in our age of brain imagery and neuro-anatomy. These historical images shape the world of the medical professional as well as that of the layperson. We all carry conflicting and competing images of what mental illness means and how it is to be affectively as well as intellectually understood. Such images have impact on the meanings associated with the science of mental illness as well as the reception and self-perception of those who are disabled because of mental illness. There is no fine line between images from the world of the health sciences dealing with mental illness and health and these popular images.² These images are interchangeable, each reifying the other. Mental illness is real because it fulfills our expectations of the image of madness; mental health is the alternative to such images. This is not to claim that mental health and mental illness do not exist. Only that they are so categorized because of how we imagine madness. Indeed, the interpretability, flexibility and malleability of the symptoms of mental illness (as with all symptoms of illness) over time reflect the expectations built on the interplay of popular and medical images. This article examines the function that debates about creativity and madness had in the construction of the disability and mental illness discourse over the past 100 years; including the popular stereotypes about mental illness (madness) that echo through the claims about mental illness as a form of disability.

¹ P.K. Longmore and L. Umansky ed., *The New Disability History: American Perspectives* (New York 2010); F. Callard, *Mental Illness, Discrimination and the Law: Fighting for Social Justice* (New York 2012).

² A. Quayson, *Aesthetic Nervousness: Disability and the Crisis of Representation* (New York 2007).

Mental Illness as History

It seems clear that mental illnesses, which allopathic medicine is now defined as neurological rather than psychiatric, have different meanings attached to them in the past than in the present. For example General Paresis of the Insane (G.P.I.), first diagnosed as a psychiatric category in 1822 by Antoine Bayle, was suggested to have a neurological cause as early as 1857 (by Friedrich von Esmnarch). This was the most often diagnosed disease among asylum inmates and turned out to be the final stages of neuro-syphilis. In the latter half of the nineteenth century, this association between neurology and symptoms of madness was only whispered about. The double stigma concerning mental illness and sexually transmitted diseases meant that it was rarely articulated. It was only after 1913 when Hideyo Noguchi and J.W. Moore were able to find syphilis spirocaetes in virtually all of the sufferers that G.P.I. was rebranded as tertiary neuro-syphilis. But not all of the sufferers of G.P.I., with its clear and marked symptoms (frozen irregular pupils, diminished Babinski reflex, radical shifts in mental states, including depression and memory loss leading to dementia), turned out to have syphilis. They were simply mad, as all with G.P.I. had been before 1913.³

The image of the person with G.P.I. is to be found in the early twentieth century as the 'mad man' without any reference to the putative cause of the illness. Thus Clifford Beers, the founder of the National Committee for Mental Hygiene, one of the very first disability advocacy groups in 1909, recounts in his autobiography *A Mind that Found Itself* (1908) seeing another victim, forty-five years of age, was one who had formerly been a successful man of affairs. Beers wrote:

His was a forceful personality, and the traits of his sane days influenced his conduct when he broke down mentally. He was in the expansive phase of paresis, a phase distinguished by an exaggerated sense of well-being, and by delusions of grandeur which are symptoms of this form as well as of several other forms of mental disease. Paresis, as everyone knows, is considered incurable and victims of it seldom live more than three or four years. In this instance, instead of trying to make the patient's last days comfortable, the attendants subjected him to a course of treatment severe enough

³ J. Braddock, B. Pike, *History of Syphilis* (Cambridge 1992).

to have sent even a sound man to an early grave. I endured privations and severe abuse for one month at the State Hospital. This man suffered in all ways worse treatment for many months.⁴

This image of the oppressed insane is a commonplace in the world of disability advocacy. It is the image of the mad, not the bad, of the disordered, not the infected.

Hidden in the background of paresis even before the discovery of the actual etiology was the assumption of sexual license. Thus also in 1908 Elisabeth Förster-Nietzsche successfully brought suit to defend the memory of her brother the philosopher Friedrich Nietzsche. He had died in 1900 after a complete mental collapse a dozen years earlier, after the biographer of Nietzsche's friend Franz Overbeck mentioned in his account that Nietzsche may have died of G.P.I. The stigma of a sexually transmitted disease, even hinted at, was enough for the court to support her charges and the offending pages were removed from the volume.⁵ Yet one of the themes that contributed to Overbeck's claim connecting Nietzsche's illness to infection was the view, very prevalent in the literature of the time, that such madness was one of the sources of true genius.⁶ We can see how malleable such a retrospective etiology – and its implications – might be in the more recent retrospective diagnosis of Nietzsche's final illness as bipolar disorder. Unlike G.P.I., bipolar disorder is a disease without moral overtones, although it carries the assumption of some type of genetic cause, something that also would not have pleased Nietzsche's sister.⁷

Bipolar Disease as 'Creative' Madness

The anthropologist Emily Martin sees herself as 'mad' – she uses this term in the preface to her book to provide a context for her account of bipolar

⁴ C. Beers, *A Mind that Found Itself* (1910 New York, 2nd edition) 171.

⁵ C.A. Bernoulli, *Franz Overbeck und Friedrich Nietzsche, eine Freundschaft*, volume 2 (Jena 1908) II; S.L. Gilman, *Begegnungen mit Nietzsche* (Bonn 1981) xi-xiii.

⁶ D. Hayden, *Pox: Genius, Madness, and the Mysteries of Syphilis* (2003 New York).

⁷ E.M. Cybulska, 'The Madness of Nietzsche: a Misdiagnosis of the Millennium?', *Hospital Medicine* 61.8 (2000) 571-575.

disorder/manic depression in the United States today.⁸ Clinically diagnosed as bipolar, she over and over documents the symptoms of her illness. She has hallucinations including that of the ‘sinister figure, a cold gray gargoyle, perched tenaciously on [her] shoulder, looking at what [she] was writing (...) and muttering a devastatingly negative commentary’ who haunted the very act of her writing. What that ‘cold gray gargoyle’ is reading over her shoulder is indeed her study of ‘mania (...) a new continent with a distant frontier, whose receding horizon invites exploration and development’.⁹ Actually, she uses this geographical phrase to describe the pharmaceutical companies seeking new drugs and new markets, but it is a very accurate view of Martin’s mapping of modern manic depression in the age of psychopharmacology.

This is a paradox for the question of madness as a disability: can you be simultaneously ‘mad’ and ‘rational’, a ‘sufferer’ and an ‘observer’? Certainly modern anthropology has wrestled with the problem of being both observer and participant, but what if the observer is mad? Martin sets this dichotomy at the core of her understanding of bipolar illness. Is mental illness (‘madness’) really incompatible with rational or (perhaps less stigmatizing) productive behavior? She is certainly not the first person to ask this question.

At the very beginning of the twentieth century Daniel Paul Schreber (1842-1911), lawyer, jurist, and failed parliamentary candidate, wrote and then published in 1903 a book length account of his mental illness.¹⁰ Schreber and his book were later both the prized subjects of studies by multiple scientists, one of which was Sigmund Freud.¹¹ Schreber published his account to prove to the director of the Dresden asylum in which he was hospitalized that he was not mad, for mad people, even crazy lawyers, simply can’t write books. He wrote his book, won his case, and was released, only to relapse and be re-hospitalized decades later. The interest in his case

⁸ E. Martin, *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton 2007).

⁹ Martin, *Bipolar Expeditions*, 15.

¹⁰ I. Macalpine, R.A. Hunter, *Memoirs of My Mental Illness* (Cambridge 1988).

¹¹ S. Freud, *Psychoanalytic notes on an autobiographical account of a case of paranoia* (1990); E. Canetti, *Crowds and Power* (New York 1960), J. Lacan, *The Seminar of Jacques Lacan: The Psychoses*, volume 3 (Norton 1993) the seminars were given in the period 1955-1956; J. Lacan, *On a Question prior to Any Possible Treatment of Psychosis* (1958); G. Deleuze, F. Guattari, *Anti-Oedipus* (1972).

as an example of psychopathology by the wide range of thinkers mentioned above was spurred by the very text that provided egress for him from the asylum.

That such a claim is not unique to Schreber and his authorship can be seen in the hospitalization of the brilliant art historian Aby Warburg in Ludwig Binswanger's sanatorium in Kreuzlingen from 1921 to 1924. He was diagnosed as 'incurably schizoid,' driven by paranoid fantasies of danger to himself and his family. There he held a talk on his 'Reminiscences from a Journey to the Pueblo Indians,' later posthumously published as *A Lecture on the Serpent Ritual*. Warburg had seen on this ritual on his visit to the Pueblos of northern New Mexico between December 1895 and May 1896. His presentation convinced Binswanger that he could now be released as 'normal'.¹²

Emily Martin reads the paradox between the rational and the insane as the key to understanding the very nature of bipolar disorder and its new function in American (and one can extrapolate – global) society. The commonplace that Schreber or Warburg successfully countered was that the mind of the 'mentally ill' is inherently fragmented and incoherent. Mental health meant the unity of all parts of the psyche, proven, for instance, by the writing of books. Mental illness signaled the disruption of such unity. No internal multiplicity of the sense of the self could exist in healthy people. In the nineteenth century, the insane could regain their coherence and their reason through orderly living – moral treatment – and thus recover their sense of full personhood. Asylums mirrored the institutions of society, holding dances for the inmates, providing work, mimicking an imagined ordered life into which the mad would return. Living with mental illness meant being insane. It meant accepting the role of the mad person in the society, beyond order and redemption.

The individuals whom Martin meets in bipolar support groups live with their bipolar disorder even when they manage it with drugs. Her account shows that individuals diagnosed as bipolar are quite aware of their multiple aspects and the course of their illness. In fact, these individuals try, often with some success, to manage the radical alternation of their moods from highs to lows without losing their sense of disorder – the lived experience of all of the states of bipolar disorder encompassing the highs

¹² M.P. Steinberg, *Images from the Region of the Pueblo Indians of North America* (Ithaca 1955); D. Stimilli ed., *Die unendliche Heilung. Aby Warburgs Krankengeschichte* (Berlin 2007).

and the lows as well as a drug-provided alternative. The individuals she observes manage their lives, whether successfully or unsuccessfully, taking into account the knowledge that their chronic mental illness is part of who they are and will always be.

Yet Martin's argument goes beyond just seeing how medicated bipolar individuals deal with their illness: she argues that at least one aspect of bipolar disorder is today seen as a model for a certain type of 'healthy' or at least productive behavior in society. This positive reading of the manic comes to be part of the way that bipolar individuals internalize their illness. The 'manic' aspect of their illness has come to be praised in the modern world as a positive character quality rather than as a sign of illness. According to Martin's insightful tabulation, corporate leaders such as Steve Jobs (of Apple) or Richard Branson (of Virgin) are seen as manic because they are risk-takers. Being manic in this sense is one of our definitions of success. Taking risks, acting beyond the limits of social boundaries, demanding the right to alter the world – all are signs of the successful entrepreneur as well as the manic patient.

Indeed, Martin shows how self-labeled manic-depressives – such as the Johns Hopkins psychologist Kay Jamison, the 1990's poster girl for bipolar disorder – create genealogies of successful 'bipolar' people. Drawing on famous individuals from Edgar Allan Poe to Vincent van Gogh to Virginia Woolf and Jackson Pollack and Theodore Roosevelt and beyond, these genealogies are engineered to show that true creativity is in no way pathological, that being bipolar is simply another form of being creative.¹³ Indeed, bipolar disorder traced through these genealogies emerges as the most valued source for all true creativity. Jamison thus quietly inserts herself and her book in this genealogy, making more or less the same claim as Schreber or Warburg. Such a claim that inexorably links creativity and madness is seen by Jamison and other such commentators as being ancient (and therefore universal), having its first articulation in Plato's theory of the 'furores'. Though Plato clearly distinguishes between creative madness and mental illness, Renaissance writers such as Marsilio Ficino elide these into the commonplace that madness is creativity. As Rudolph and Margot Wittkower's note 'Seneca's often quoted dictum: 'nullum magnum ingenium sine mixtura dementiae fuit' [there never has been great talent without some touch of madness] would seem to express this point of view. In actual fact,

¹³ K.R. Jamison, *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (New York 1996).

Seneca's further comment leaves no doubt that he referred to the Platonic fire of divine inspiration rather than to 'insanity'.¹⁴ By the 19th century, the view that madness and creativity were inexorably linked had become a commonplace within clinical psychiatry, especially in the work of Cesare Lombroso (1836-1909) and Paul Moebius (1853-1907). This claim, fostered by many among disability advocates for the mentally ill, more often than not collides with the lived experience of people with bipolar disorder whose mania is as destructive to their lives as is their depression. This lived experience stands in sharp contrast to a contemporary culture that claims the manic state as a truly productive one. Now this, too, is a paradox that Martin avoids: she understands very well that the label manic is not the same as the lived experience of people with bipolar disorder, that creativity can be destroyed by the illness as well as furthered by it, that an individual, such as Kay Jamison merely being able to write that brilliant and well-received book, is not a proof of the positive nature of the experience of illness for all those who live with it.¹⁵ Indeed, Jamison's accomplishment is not even proof of the value of mania as a wellspring to creativity. It is quite possible to write in spite of and not because of one's illness – which is an answer to those who claim that creativity is proof of the value of mental illness.

Martin shows how the claims of a special creative potential in people with bipolar disorder collide with the life experience of manic-depressive individuals. For Martin sees that the changing categories of mental illness reflect societal images of what madness is and that those who are diagnosed as mentally ill shape their perception of their illness based on these changing expectations. 'Does society claim that I am creative because I am bipolar – then I had better live out that claim.'¹⁶ As Martin notes, when you are given a diagnosis that diagnosis becomes part of who you are. She does not claim that madness is merely an invention of society. She is quite happy to speak of the biological and perhaps even genetic underpinnings of bipolar illness. But she sees that the lived experience of mental illness is altered by the changing meanings ascribed to it. Thus in the nineteenth century mania was seen as a feminine quality (enthusiasm), unhealthily present in men while depression was a masculine quality (seriousness) present in women. Today,

¹⁴ R. Wittkower, M. Wittkower, *Born Under Saturn: The Character and Conduct of Artists* (New York 1969) 98.

¹⁵ K.R. Jamison, *An Unquiet Mind: A Memoir of Moods and Madness* (New York 1995).

¹⁶ Martin, *Bipolar Expeditions*, 129.

the claims are quite reversed and mania has become the sign of a successful male competitor such as Branson or Jobs.

The view that diagnostic categories reflect social meaning and impact on the individual's sense of themselves is certainly not only true of mental illness. Some people with cancer (an unspoken word a generation ago) now proudly wear a pink ribbon. Breast cancer has become socially acceptable as the woman's illness, even though many more women die today of heart disease than breast cancer. The still unspeakable disease of men is prostrate cancer. It is an illness that impacts on many more men than the numbers of women who suffer from breast cancer and evokes the same type of sexual mutilation now answered by the pink ribbon. There is a little known blue ribbon movement for prostate cancer (pink for girls; blue for boys). But few wear these ribbons today. The meanings as well as the rituals that are attributed to suffering from a disease shift as we rethink their function in society. Images of healthy and ill are formed and focused by societal pressures to create concrete ideas of illness. As Eduard Bernays, one of the creators of modern advertising, wrote about public images: 'any person or organization depends ultimately on public approval, and is therefore faced with the problem of engineering the public's consent to a program or goal'.¹⁷ This is equally true of the meanings associated with representations of mental illness.

One of Martin's claims is that evidence-based medicine creates clearly differentiated and self-limited categories of mental illness. These categories are often defined by the responses to drugs provided by the pharmaceutical companies who need to identify patient populations they can cure. Such claims not only define the very nature of the disease but also the individual's response. 'I am bipolar' is a very different claim than 'I have debilitating periods of depression and mania.' Martin is in no way anti-pharmacology. She documents her own use of (and benefit from) psychotropic drugs. Yet she shows how drugs are given personalities by the drug companies (in their ads to physicians and in the public media) and by patients alike. Zoloft is, according to one user, 'like a little robin's egg, it has that blue color and it represents hope'¹⁸ – a very different blue from that of the prostate cancer ribbon! If one claims 'I am bipolar', this is the perfect drug to answer my sense of hopelessness. The shape, color and form of drugs, as Martin carefully documents in her field work in the drug companies, are very

¹⁷ E. Bernays, *Public Relations* (Norman 1952) 9.

¹⁸ Martin, *Bipolar Expeditions*, 162.

purposefully worked out: red is a bad color as it seems to evoke the hectic intensity of mania rather than counter it; blue is claimed to be a calming and peaceful color. All are part of a culture of defining mental illness and its treatment, which shifts from culture to culture and epoch to epoch. What disables the individual with mental illness may not only be the illness they have but the meanings they and their world attach to that illness. Are they disabled when they write about their mental states and, if so, what does disability mean in this context?

It is evident that to attempt to capture the relationship between madness and disability is to define one ambiguous and constantly shifting term by another. Madness has for centuries had legal and medical meanings, those meanings are more tangled and subject to political/ideological pressures than ever today in light of the framing of madness as a type of disability. For madness has now not only to figure itself in relation to ideas about competency, moral ability, curability, etc. but also in relation to questions of access, stigma, and advocacy.¹⁹ Madness thus evokes not only the wide range of stereotypes of psychological difference, from the Greeks to the present, but also the lived experience of those who understand themselves and are understood as being mad. The term suggests the medical, social, and cultural categories dealing with all forms of psychic pain that came under the purview of alienists, psychiatrists, and neurologists. By contrast, madness can also be understood from a patient/client/inmate perspective rather than that of a psychiatric practitioner or clinician's perspective.

Madness as Disability

What seems to define madness in relationship to disability is the concept of psychic pain (or anguish or suffering). This certainly plays a major role in Emily Martin's account of bipolar disorder. The very existence of psychic pain, for example, is today thought to be a contested source of knowledge, having its modern origins in John Locke's view that '(...) pain [is] (...) sometimes occasioned by disorder in the Body, sometimes by Thoughts of

¹⁹ F. Pelka, *What We Have Done: An Oral History of the Disability Rights Movement* (Amherst 2012).

the Mind'.²⁰ However else madness has been defined, such psychic pain was and remains a litmus test for madness, whether as a reason for intervention or as a perceived source for greater insight into the mad and their creative capacities.

A broad understanding of madness therefore must account for medical perspectives, both allopathic and complementary/alternative practices, as well as multiple social, political, and cultural understandings of madness and mad people, all fluid and ever moving across the world. Every society has its own categories and perspectives and experiences of madness – from melancholia in ancient Athens to spirit madness in modern Evangelical churches; from the representations of madness of American medical missionaries in China in the nineteenth century to those selling cures for madness in the botanicas of the Dominicans in New York City today. Across the globe, societies see categories of madness as something that impinges on human activity, for ill or for good, and with a variety of meanings that generate a variety of interpretations. The realities of what constitutes madness in any given society or community or historical moment are constantly shifting: symptoms change and their meanings seem always in flux. Even as different etiologies and meanings of madness emerge to explain the somatic, psychological, social, and cultural causes of madness, psychic pain remains central to all of these categories. Madness may be the antithesis of what is called normal. Likewise, it may be related to other categories of illness and pain, or be a state that transcends the normal.²¹

Similarly, if we explore madness not in the realm of a medicalized society, but in the parallel world of the law, then madness takes on yet other colorations. The two realms are intertwined. From the forensic definitions of madness created by the Romans, which focused on competency, aging, and property, to the McNaughton rule of Victorian England, which focused on the moral ability to know right for wrong in the case of Daniel McNaughton, who attempted to assassinate the British Prime Minister Robert Peel in 1843, we see legal definitions of madness that parallel and mimic medical and social definitions of madness. But these legal definitions are also autonomous. Today, one does not speak of madness but rather of

²⁰ J. Locke, *Essay on Human Understanding* (1690) II, chapter 20, 113 (New York: Continuum International Publishing Group, Limited, 2003).

²¹ S.L. Gilman, *Seeing the Insane: A Cultural History of Psychiatric Illustration* (New York 1982); R. Porter, *Madness: A Brief History* (Oxford 2003).

psychiatric illness or diagnosis in the world of law. Yet the contemporary functional definition within the law remains inherently one developed by Victorian alienists. This often leads to complicated political response to the use of the incompetency defense in court, especially in high profile cases of political assassination, such as in the murder of President James Garfield by Charles Guiteau in 1881, or infanticide (the use of the post-natal psychosis in the case of Susan Smith in 1995). In both cases the defense, using a version of the McNaughton rule, was unsuccessful. At least a few American states (Montana, Idaho, and Utah) have now banned this defense.²²

Mental Pain

It is thus imperative to sort out what we mean when we use the categories of madness and psychic pain that define our object. Once we have settled on a particular definition or construct of madness, then we can ask how these limits impact on our understanding of those who are defined by these limits. Central to all definitions of madness is the idea of innate difference that is associated with it. This stereotype may be positive – debates about creativity and madness, for instance, go back to the ancient times – but most have negative consequences. These include physically isolating the mad from society, refusing to give the same rights to the mad as to other citizens, and seeing madness as a diminution of one’s humanity.

The Greeks regarded madness as the result of a physical imbalance of the four humors (black bile, yellow bile, phlegm, and blood), the bodily fluids that they believed regulated health and temperament. Because of this they created melancholic, choleric, phlegmatic, and sanguine temperaments and their attendant illnesses. The Chinese at the same time conceived of madness as an imbalance of the primal forces of yin and yang. Jewish beliefs, mirrored in the accounts in the Tanach (Old Testament), stressed moral failing and divine intervention as a primary cause of madness as in the case of Nebuchadnezzar (Daniel 4:31-33) but also as in Samuel 10:6 the voice of the often unrecognized prophet. All of these cultures placed the mad in a separate category: for some a higher one of prophecy and illumination, but for most one of marginality and exclusion. All developed some types of therapeutic interventions for the latter, not necessarily for the former.

²² C. Millard, *Destiny of the Republic: A Tale of Madness, Medicine and the Murder of a President* (New York 2011); G. Rekers, S. Smith, *Victim or Murderer* (Centennial 1995).

Roman and, later, medieval medicine and society made the distinction between the naturally born idiot and the lunatic, terms that overlap with and permeate medieval law and medicine. The former were not seen as treatable, but the latter were. The moral stigma and legal treatment of both, however, were clearly parallel. The question of causation mixed theological, physiological and mystical etiologies, to varying degrees at different times and places. The means of treatment were similarly mixed: from spiritual exorcism to the use of somatic interventions such as diet to restore mental balance and physical control and restrain the individual from actions that could harm their estates. This was also the case in Islamic medicine, which had transmitted much of Greco-Roman social and medical attitudes on madness in the Middle Ages to Europe but which also was permeated by Christian and Jewish medical practice in Europe and beyond. According to Sura 4:5 of the Qur'an:

Give not unto the foolish what is in your keeping of their wealth,
which Allah hath given you to maintain; but feed and clothe them
from it, and speak kindly unto them.

This is a cultural translation of the Roman medico-forensic notions of 'furiosus' and 'non compos mentis' in limiting economic damage to an estate by a mad parent's fiscal irresponsibility, a notion that is itself linked to the theological understanding of madness from the New Testament (Matthew 4:24).²³

As the notion of the hospital evolved in the early Middle Ages, specialized institutions for the mad developed as early as 705 A.D. in Baghdad. This tradition had spread into Spain and Western Europe by the late Middle Ages. While a form of medical incarceration appeared for diseases such as leprosy and madness, the mad were rarely permanently housed in such facilities. Unlike lepers, who were understood to be contagious, they were usually incarcerated for a limited time, usually because of the costs to local communities for extended confinement, and then released. Leprosy and madness generated a sense of dread derived from the prevalent images of the leper and the insane. It was of little surprise that specific institutions grew up to socially isolate these sources of public anxiety. By the Renaissance, madness also became a conceit for the view

²³ D. Robinson, *Wild Beasts and Idle Humors: The Insanity Defense from Antiquity to the Present* (Cambridge 1998).

that one's mad actions could be a sign of sanity in a world gone mad. As William Shakespeare had Hamlet say in 1601: 'I essentially am not in madness, But mad in craft'.²⁴ This view of madness as a metaphor for sanity in an unstable world would become a commonplace of Romantic views of insanity and, indeed, part of the idea of madness thereafter.

By the nineteenth century in Western Europe the idea of a moral treatment of the insane, as well as the isolation of the idiots seen as inherently incurable from the treatable lunatics, was generally accepted. Moral treatment aimed at the return of the lunatics to their proper place in the world through the moral and secular correction of the misunderstandings of the world and their inappropriate actions. Thus weekly dances for the inmates were a standard practice in the reformed asylum to reestablish the moral order of their inmates. Led by lay directors, such clinical facilities gave way in the course of the nineteenth century to an ever-greater degree of medicalization across Europe and North America, so much so that their directors by the close of the century were virtually all medically-trained alienists. This development in treatment paralleled the professionalization of psychiatry and neurology and the creation of a systematic set of diagnostic categories as well as treatments. Most of these were based on physiological principles, though strongly psychological interventions paralleled them at the close of the century. Suddenly madness as a category gave way to other terms such as 'affective disorder' as John. Bucknill and Daniel Tuke state in their standard *Manual of Psychological Medicine*.²⁵

Even so, the nineteenth century placed its emphasis on somatic definitions of madness. Wilhelm Griesinger in 1868 wrote: 'The so-called mental illnesses are found in individuals suffering from brain- and nerve illness'.²⁶ By the 1890s this view seemed to be universal in Western psychiatry. The neurologists of the time, such as the young Sigmund Freud, assumed this as a fact but question the relationship between organic sources of madness and the wide range of psychological manifestations of mental illness. Freud began a movement, psychoanalysis, which accounts for the

²⁴ W. Shakespeare, *Hamlet*, Act III, Part IV (1601), www.shakespeare-online.com, Viewed on: 1 July 2014.

²⁵ J.C. Bucknill, D.H. Tuke, *Manual of Psychological Medicine* (1858 London) 125.

²⁶ W. Griesinger, 'Vorwort' in: B. von Gudden, I. Meyer ed., Th. Meynert, *Archiv für Psychiatrie und Nervenkrankheiten*, Volume 1 (Berlin 1868), iii-viii.

widest range of mental states as potentially leading to psychic pain yet without any direct organic cause. Indeed, Freud's great insight is that bodily symptoms, such as paralysis, can have purely psychological causes and should be treated by psychological interventions such as talk therapy rather than physical treatments such as electrotherapy.²⁷

The somatization of madness increased across the twentieth century, but it came at a cost. More and more symptoms were related to specific neurological deficits such as dementia. Development disorders came to be sorted out from illnesses with complex neurological causes – reductively dividing environmental diseases from genetic ones, for example – and thus further separating out those diseases seen as purely illness of the spirit, the psyche, or the mind. Thus the idiot and the lunatic, often housed in the same state institution through the nineteenth century, were by the early twentieth century seen as manifesting quite different social and medical causes.²⁸ Indeed biological interventions such as sterilization dealt with such individuals not to aid them but to improve society by eliminating their ability to reproduce. As the United States Supreme Court justice Oliver Wendell Holmes Jr. concluded in affirming the Commonwealth of Virginia's eugenic sterilization law:

It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.²⁹

Biological definitions of madness generated a wide range of biological interventions to limit and control madness.

Yet the greater the detail knowledge of the causes and meanings of madness the more the boundaries that defined it begin to shift. Thus general paralysis of the insane, the most common diagnosis for psychiatric patients in the nineteenth century asylum, came to be recognized as the last

²⁷ S.L. Gilman, *The Case of Sigmund Freud: Medicine and Identity at the Fin de Siècle* (Baltimore 1993).

²⁸ J.W. Trent Jr., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkeley 1994).

²⁹ *Buck v. Bell*, 274 U.S. 200 (1927).

stages of syphilitic infection following the development of a specific test for the syphilis spirochetes in 1906; it thus became a potentially treatable neurological disease rather than a form of mental illness. After specific treatments for syphilis were developed, general paralysis of the insane simply vanished from the diagnostic repertoire of most physicians who dealt with madness and the treatment of its characteristic symptoms entered other medical specialties.

Madness and Neurodiversity

The desire in the twentieth century was to find more and more cases in which madness was the result of specific biological, neurological, or genetic factors. Eugenic interventions, such as sterilization, came to be repudiated (if slowly) after the horrors of the Holocaust and its eugenically inspired mass murder of 'inferior races' as well as the disabled. Compulsory sterilization laws for madness existed in the United States from 1897 to well into the late 1970s and still occurs in isolated cases, such as the California prison system, until today. In light of the Holocaust, post-WWII medicine sought specific bio-medical interventions (mainly psychotropic drugs) that could have an impact on the symptoms of madness, then defined in terms of psychosis, a lesser or greater loss of the psychic connection to reality, and neurosis, the impairment of rationality that leads to psychic pain.³⁰

Developmental disorders seem to have been bracketed in the search for a cure for a drug to cure madness. Yet the discovery of DNA in 1952 and the subsequent discovery of the specific mutations for Down's Syndrome in 1959 were more or less simultaneous with the first uses of lithium to treat the symptoms of depression and Thorazine (chlorpromazine hydrochloride) in 1950 to treat the symptoms of schizophrenia. The idea that there could be a genetic intervention to prevent all such developmental disorders is also an artifact of this post-WWII science as much as the now seemingly universal use of psychotropic drugs, from that first anti-psychotic medication in the 1950s to mood enhancers (Prozac) to drugs to treat hyperactivity (Ritalin). The expansion of drug treatment was first heralded by patients and physicians alike as effective interventions but quickly became a target of patient and social discontent given massive side-effects

³⁰ E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York 1998).

as well as the over-prescription of many such drugs to ever widening categories of individuals. Madness seemed to become quotidian and yet the stigma of madness remained.

With the expansion of psychotropic drug use, the patient self-consciously became the client and with such shift of definition became more and more self-aware. Twentieth- and twenty-first-century patient populations are now, in effect, consumers of medical care, and as consumers they organize and make demands – demands that range from the call for de-institutionalization and the closing of large public facilities housing individuals believed to be unable to function in the world to the desire to be released from the negative stigma of madness.

The rise of a contested science of madness in the nineteenth century provides a basis for the medical treatment of mental states as illnesses in the systematic classification of forms of mental (and other) illness. Begun in 1893 by Jacques Bertillon as a positivistic description of illness based on observable symptoms and analogous to his work in criminology, this soon became a global phenomenon. Revised in 1898 by the American Public Health Association as the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD) it was only after 1948 that the World Health Organization's International Statistical Classification of Diseases and Related Health Problems appeared. It became the gold standard for international psychiatric classification, especially after its 8th edition of 1968. In 1973, the Diagnostic and Statistical Manual of the American Psychiatric Association, which had first appeared in 1952, assumed a global role in unifying the terminology for psychiatric classification. What was remarkable about these widely accepted means of describing mental illness is that they codified the contemporary views and attitudes towards madness globally rather than locally. And by doing so they claimed a scientific uniformity that existed only within their own closed systems.

In the 1960s, alternative perspectives on madness began to emerge in the works of Erving Goffman, R. D. Laing, and Thomas Szasz, offering a re-examination of the social causes of madness. These had a powerful impact on the de-medicalization of madness among feminist and gay activists in the 1970s. Where Goffman saw the asylum as a repressive means of social control, Szasz saw madness as invented by the patient as well as society. Laing saw madness as the 'healthy' product of sick social or familial structures. All of these models contributed to the growing patient empowerment movement of the time and began to shape the idea of

disability beyond the medical model of rehabilitation (taken from interventions related to deafness and blindness) that had dominated the field from the 18th century.³¹ The idea of a relativization of madness (now freed of any medical implication) first appeared in sociological work in France in the work of Georges Canguilhem in the 1940s and, later, with his student Michel Foucault in the 1960s. In *Folie et Dérison. Histoire de la folie à l'âge Classique* (1961), Foucault dismissed the antithesis of sanity and madness as the result of medical power.³² One concrete result was that entire categories of madness such as homosexuality (in 1973) and premenstrual syndrome (in 1987) came to be dismissed from psychiatric diagnosis. More generally, the very idea of madness came to be suspect as stigmatizing rather than diagnosing.

Medical discourses of rehabilitation and disability inspired the creation of the category of psychiatric disability following the 1980 World Health Organization's International Classification of Impairments, Disabilities and Handicaps of disability as the result of illness. Thus a psychiatric disability can be the result of a psychiatric impairment, which can be the source of the stigma of madness that impinges on the ability of the individual to function in the community. Different from other disabilities, such as developmental disabilities, psychiatric disabilities are seen as episodic and intermittent. But here the acknowledgement of the causality of the stigma of madness does not touch the underlying medical assumptions about the meaning of madness.

One reaction to this medicalized model of disability within the disability rights movement (and its allied academic field of disability studies) is to begin to see all forms of mental ability and emotional stability as ranged on a spectrum. The concept of a spectrum of human psychological/mental diversity comes as an answer to the older model of psychiatric disability. Harvey Blume coined the term 'neurodiversity' in 1998 as a defining quality of being human:

Neurodiversity may be every bit as crucial for the human race as biodiversity is for life in general. Who can say what form of wiring

³¹ W. Sayers, *A History of Disability* (Michigan 1999).

³² M. Foucault, *History of Madness* (New York 2006) edited by J. Khalifa and translated by J. Murphy.

will prove best at any given moment? Cybernetics and computer culture, for example, may favor a somewhat autistic cast of mind.³³

This followed from work in disability studies that spoke of the 'extraordinary' body, the 'rejected' body or the 'recovering' body or, more recently, the 'problem' body.³⁴ Disability thus dealt the 'reception or construction of [the] difference' presented by a 'physical or mental impairment'.³⁵ Here one suddenly has the idea of the extraordinary, rejected, recovering, or problem mind.

Such ideas of madness and disability develop parallel to the growth of popular interest in autism, which also comes to be the litmus test of the new test case for madness within disability studies. As Paul Hellker and Melanie Yergeau note, 'Public awareness and public discourse about autism are approaching critical mass'.³⁶ Medically, autism has been defined as a psychiatric category since the early twentieth century. It is now seen as a developmental disorder with genetic or environmental causes. Certainly the flawed claims about MMR vaccination as the cause of autism colored its reevaluation at the end of the twentieth century by stressing the potential elimination of autism through social action rather than through genetic or medical intervention.

Today autism is increasingly seen as an alternative, even a preferred mental state, rather than as a deficit. It is the answer to Erich Fromm's view that madness in modern society is a sign of humanity's fall from 'biophilia', that is, from a sense of relatedness, rootedness and orientation.³⁷ Autism has come to be a sign that individual autonomy can challenge and often

³³ H. Blume, *Neurodiversity* (1998),

<http://www.theatlantic.com/doc/199809u/neurodiversity>. Viewed on: 22 September 2013.

³⁴ R. Garland-Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York 1997); S. Wendell, *The Rejected Body: Feminist Philosophical Reflections on Disability* (New York 1996); T. Couser, *Recovering Bodies: Illness, Disability, and Lifewriting* (Madison 1997); S. Chivers, M. Nicole, *The Problem Body: Projecting Disability on Film* (Columbus 2010).

³⁵ L.J. Davis, 'Dr. Johnson, Amelia, and the Discourse of Disability in the 18th century' in: H. Deutsch, F. Nussbaum ed., *'Defects' Engendering the Modern Body* (Ann Arbor 2000) 54-74: 56.

³⁶ P. Helker, M. Yergeau, 'Autism and Rhetoric', *College English* 73.5 (2011) 485-497: 485.

³⁷ E. Fromm, *The Sane Society* (New York 1955).

overcome notions of social isolation.³⁸ The fascination with idiot savants in the late-twentieth-century public sphere (such as the autistic Raymond in Barry Levinson's film *Rain Man* (1988)) gives way to a new focus on the autistic individual as a representative of neurodiversity. Asperger's Syndrome is the new norm, exemplified by the film *Temple Grandin* [2010], Mick Jackson's biopic that describes the youth of Temple Grandin, the iconic autist who is a professor at Colorado State University and Max Mayer's *Adam* (2009), the account of a young man suffering from Asperger's Syndrome. This framing of autism draws on debates about the autonomy of the client/patient from the 1960s and the image of a broader spectrum of mental health held by disability studies scholars. It rejects any sense of the autist as being severely impaired and in need of special facilities, only differently enabled. Indeed, both activists and scholars of disability have promoted the growing sense that autists are actually better enabled in a world that does not recognize their abilities. This is the theme of the best-selling 2003 novel by Mark Haddon, *The Curious Incident of the Dog in the Night-Time*. (See the various positions in the special issue of the *Disability Studies Quarterly* on neurodiversity devoted to autism.³⁹) This view is very much in line with the reinterpretation of bipolar disorder as the source of creativity by bipolar writers such as Jamison.

The need for public facilities for severely impacted autistic people has diminished as quickly in the twenty-first century as it did for the mad in general during the 1960s. The source of this decline is the sense that autistic individuals must function as part of a newly redefined public sphere that, according to law and custom, is now open to them, no matter how severe their individual state. The model for this is the treatment of Asperger's Syndrome rather than severe, debilitating autism. Thus the politics of disability and madness can be clearly seen in the debates about autism in the twenty-first century. The Americans with Disabilities Act (1990) defines disabling madness as 'any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities' that 'substantially limits one or more major life activities of an individual' or that cause one to be 'regarded as having such an impairment'. Both aspects of this definition assume a psychiatric

³⁸ S. Murray, *Autism* (New York 2012).

³⁹ E.T. Savarese, R.J. Savarese ed., Special Issue: Autism and the Concept of Neurodiversity, *Disability Studies Quarterly* 30.1(2010).

diagnosis. The British Disability Discrimination Act (1995) follows the standard handbooks of psychiatric diagnosis as well as the idea that such forms of mental illness must be chronic or recurrent.

In 2011, the Neurodevelopmental Work Group, led by Susan Swedo, MD, senior investigator at the National Institute of Mental Health, was tasked with revising the category of autism in the standard American diagnostic handbook of psychiatry, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). They first suggested that the definitions of autism spectrum disorder be reworked and simplified. In DSM-IV, patients could be diagnosed with four separate disorders: autistic disorder, Asperger's disorder, childhood disintegrative disorder, or the catch-all diagnosis of pervasive developmental disorder not otherwise specified. It was proposed to unify and clarify these categories.

The reaction from the autism community in 2011, now well organized into political lobbying organizations with substantial funding raising capacity and celebrity spokespeople, was swift and damning, seeing this medical decision as impacting on the funding for autistic clients as well as the exclusion of certain forms of autism from coverage in the law. The claim was that Asperger's syndrome and about 25 percent of those with other diagnoses of autism would not qualify under the new DSM-5 category. The psychiatrists who suggested the reforms to DSM-5 quickly backtracked and the revision of the diagnostic category of autism spectrum disorders was again revised. When DSM-5 was eventually published in 2013, it reflected the political interaction between disability advocacy groups and the psychiatric community.⁴⁰

The autists who successfully pressured the drafting committee for DSM-5 acted in complex ways. They demanded more medicalization (or at least reversing a trend toward de-medicalization) but at the same time they were able to exhibit their political clout as an interest group. Since the drift of most disability activism is to de-medicalize disability, this is a counter-thrust. Neurodiversity is their cry but they also want to preserve their medical coverage and legal protections. The medical model for madness is still potent even as the disability world begins to try and erode its power. The autists do erode the power of the medical community by putting pressure on them to reverse their decision, but the result is more rather than

⁴⁰ A. Francis, *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (New York 2013).

less medicalization. For autists as well as others diagnosed with mental illness or neurological disorder today, adopting the medical model of madness can still confer tactical advantage for some disability groups. Emily Martin showed this in the case of bipolar disorder, but it may well now be a truism in terms of how contemporary society deals with madness.