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Viewing Constructions of Insanity and Mental Health through a Critical Lens

For as long as the human intellect has been documented, individuals have maintained curiosity towards the emotional, behavioral, and social dimensions of being. It comes as no surprise that our current world continues inquiring about the realm of "mental health", questioning how it manifests physiologically and gets expressed outwardly. Far from being an objective practice, observing, interpreting, and acting on meanings constructed of mental health remains an intersubjective process involving multiple stakeholders. And, indeed, the stakes are high. Pronouncements of individuals' mental health, particularly regarding diagnoses, play a significant role in shaping the trajectory of persons' lives indefinitely. Given the myriad of consequences tied to diagnostic practices, Cristina Hanganu-Bresch and Carol Berkenkotter's 2019 book, *Diagnosing Madness: The Discursive Construction of the Psychiatric Patient, 1850-1920*, examines the historical underpinnings of insanity in the making. By viewing insanity through a rhetorical lens, the authors illustrate how patients, doctors, families, legal professionals, and the general public negotiate meanings for and corrective actions towards this construct (p. 2). Guiding their investigation, the authors pose the questions: "*At what point does public interest prevail over individual rights? Is justice possible—and compatible with humane and correct psychiatric treatment of those who need it? Where does 'normal' end and 'abnormal' begin? Is it possible to understand insanity, treat it fairly, dissect it, respect it, historicize it, and incorporate it in our juridical proceedings in such a way so that justice can be achieved?*" (p. 18).

Before moving further into this review, I first ask readers to again read the questions posed above. What words stand out? What feelings do they evoke? What social observations and/or personal experiences do you, the reader, bring to bear for engaging with these questions? I raise these queries to call upon our awareness of the rhetoric at work in the dialogue of this very moment, a dialogue of which are all a part. In some way, we all participate in negotiating and enacting meanings—historical and present day—that construct mental health. Furthermore, depending on our observations and experiences, we occupy different subject positions in this negotiation and thus must remain acutely aware and critical of our individual understandings and from where they come.

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Admittedly, as one who has experienced mental health challenges of her own while receiving conflicting medical diagnoses, my attention lingers over the notions of justice, normality, and fairness. Let there be no mistake about it: the moment when our minds and ways of expressing ourselves in the world become subjects under scrutiny, it is not just our health, but also who we are that gets questioned. Who is entitled to issue such questioning? Moreover, who is permitted to speak and respond to such questioning? These queries dwell at the center of Hanganu-Bresch and Berkenkotter's work. They call upon readers to contemplate notions of justice for the sake of understanding what constitutes humane practice, particularly when competing interests between individual rights and institutional surveillance clash (p. 7). As such, they turn to historical documents to observe how insanity was first conceived and tied to corrective actions involving confinement. Few studies have looked at primary documents, case notes, and admission documents that log the diagnostic experiences of lay persons (most have looked at famous cases that led to drastic changes or made headlines, not ordinary patients). Through examining these documents, the authors' methodology involves a rich, rhetorical analysis of an assortment of historical texts while interweaving theoretical observations of bidirectionality, speech acts, and narrative to name a few. For readers, I highlight key themes from this work while also posing questions to evoke further inquiry and discussion.

Mental health and social normality are co-constitutive. With mental health abnormalities historically associated with crime, judicial and medical bodies were and still are called into action to decipher appropriate responses for helping individuals while also protecting the general public. The authors claim, "Both psychiatry and law overlap in their desire to define and regulate the normal and provide remedies to restore normality when it is disturbed or violated in some way" (p. 26). A critical eye recognizes, here, that interests in preserving normality often exclude and/or lead to the mistreatment for many individuals. Explaining the social construction of norms, Hanganu-Bresch and Berkenkotter bring attention to how conceptions of normality often dismiss the phenomenological and contextual constituencies impacting how humans respond to their lived circumstances. Hence, the norms relied upon for diagnosing individuals as insane are abstract at most and removed from the systemic realities to which individuals' expressive actions are closely tied. Such a view conceives the origins of abnormality as within individuals—that people themselves are the root of the problems observed. I urge the author to speak more explicitly about the implications of how this historical way of seeing may still proliferate in our present world at the expense of recognizing the dynamic nexus—between persons and their environments—that constitutes mental health. (Note: I elaborate further on this probing later in this review.)

Through surveying different rhetorical texts and case studies, the authors also demonstrate how varied discourses compete for legitimacy. Upon examining admissions records from Ticehurst Asylum in Sussex, England, dated between 1845-1917, the authors bring forth how doctors' admissions forms were often read prior to patients' testimonies; thus, patients' perspectives were often preceded by and read—filtered—through the lens of medical expertise. Drawing upon speech act theory, the authors demonstrate how the sequence through which this content was generated, read, and pieced together, had significant implications for how patients were seen as insane, especially when psychiatric expertise framed how perspective audiences interpreted stories told by patients (p. 68). Following a case example of Walter Marshall, a patient found to be wrongfully confined, the authors stated, "despite the checks and balances, patients could feel that they have been wrongfully confined and that although

they did indeed suffer from symptoms of a mental disorder, being confined in an asylum might well have exacerbated their symptoms rather than improved them" (p. 71).

Similar findings emerged when the authors explored the contrasts between personal testimonies and institutional discourses regarding "wrongful confinement." For instance, the personal stories told by Herman Charles Merivale and Walter Marshall, two men who were released from the asylum after being found *not* mad, suggested that confinement led them to insanity, whereas institutional narratives suggested that insanity led to their confinement (p. 86). The authors demonstrate how the narratives explored embody different temporalities that direct listeners' and readers' attention in unique ways. The personal narratives follow a symphonic time, one that expands and illuminates emotions, experiences, and feelings—time that is not strictly event-based. Institutional narratives, however, focus more on events in their chronological order, thus dismissing the "lived" elements of what such stories are like to experience (p. 86). This does not make one of these stories more "true" *per se*, but it does demonstrate how the truth for a single case may be construed quite differently. Ultimately, these contrasts bring to light how individual stories and how surrounding narratives (i.e. master plots) complicate the controversies surrounding mental health diagnosis. With ranging degrees of "truth" in the absence of "Truth," we see how aims for seeking objective practices were routinely disrupted by contrasting "true" stories (see Campanario & Yost, 2017).

The clashing of truth, power and voice are crucial, implicit themes throughout the book. Language, identity, and social status are a few among the many factors playing into the power dynamics of diagnostic practice. In the historical documents, we see how those with professional titles are "authorized" to inscribe meaning for others' supposed insanity. And while there may not be anything inherently wrong with having outsiders pronounce descriptions of others, these "authority accounts" are often valued with greater trust than the accounts of individuals lived testimonies. Inadvertently, this belief in medical practitioners denies individuals as experts on their own lives and subjects them to systems of control wherein they are often rendered powerless. As the authors claim,

> In a system aimed at self-preservation rather than rehabilitation, patients have no choice but to submit to the ministrations of asylum physicians and attendants; the indignities they suffered (being administered enemas and purgatives, being wrapped in a sheet and submersed in cold water, being strapped into a bed) are well documented in nineteenth-century patient memoirs (p. 57).

Upon reviewing the case documents for John Horatio Baldwin, the first person diagnosed with manic depressive anxiety at the Ticehurst Asylum, the authors provide a rich illustration of the diagnostic practices enacted by psychologists and practitioners monitoring the case. Before looking at the case specifically, the authors examine discourses occurring in the broader realm of medical diagnosis, particularly related to the work of Emil Kraepelin, a psychiatrist who played a key role in constructing manic-depressive insanity (MDI). His ideas initiated a widespread uptake across the medical field through medical journals, professional associations, psychiatric textbooks, and diagnostic manuals. These documents trickled into medical records and case documents that resulted in material outcomes for individuals' lives. The authors state, "When the vocabulary set is applied to actual patients, we find ourselves in the realm of uptake, or rhetorical action: a modern psychiatric label carries real-life consequences for the patient in terms of care, length of hospitalization, medical interventions, legal status, and so forth" (p. 107).

Using Baldwin's case as an example, the authors illustrate how these diagnostic forms took shape. Psychiatrists documented his symptoms closely, initially attending heavily to the

most sensational episodes in the patient's behavior. This demonstrates a case of "symptoms in search of a concept," whereby the observations gathered could be clustered under a categorical term—in this case, MDI (p. 117; see also Berkenkotter & Hanganu-Bresch, 2011). The authors argued "that by 1918 the term manic-depressive insanity had become a term of art enregistered in the vocabulary of practicing psychiatrists, and as such, the patterns that used to be obscured by a thick layer of pathological description emerge once the stencil of the Kraepelinian categories is applied" (p. 123). This stenciling created a framework that elevated psychiatrists (and other diagnostic professionals) to see what language primes them to observe. As a result, this shifts the diagnostic practice from being an inductive process to a deductive practice, whereby the qualitative differences between and among patients become subsumed (if not overlooked) under a label. Because labels expedite the diagnostic process, it is no surprise why diagnostic manuals and efforts to gather "symptoms in search of a concept" became highly valued over time (Berkenkotter & Hanganu-Bresch, 2011). The authors noted, "as the diagnosis sharpened into a label, the patient disappeared from the notes. The rich descriptive psychopathy that used to accompany patients such as Baldwin, which offered a rich topographical landscape of their lives and behavior, was smoothed over and rendered invisible under the stamped label of the diagnosis" (p. 129). Furthermore, the authors concluded, "It was a welcome path for the doctor who diagnosed and treated the patient; however, it was anonymizing for the patient, who disappeared in the notes, a faint metronomic beat flattened into a mechanical echo" (p. 130). I ask Hanganu-Bresch, in what ways do these historical observations play into our current diagnostic environment?

I invite the author to now take further steps towards bridging connections between this historical exploration with modern theorists who observe the benefits and consequences of diagnostic categories that, one might argue, are becoming increasingly dehumanizing (that is, calculated prescriptions that leave little room for inductive inquiry about individuals' lives and manifest conditions). This again bears significant implications regarding power (which the authors imply in the book and set the stage for exploring in greater depth), and who has the "authority" to pronounce meaning for individuals' health experiences. With the uptake of diagnostic terminology, we all—medical professionals and lay persons alike—are swayed by the linguistic instruments that function as "equipment for living" (see Burke, 1973) for navigating sensorial and behavioral qualities of human life. As such, we often discount the phenomenological roots of our existence, operating instead in a world of language removed from the immediate moments in which individual experiences emerge. What forms of expression exist that might reawaken our phenomenological sensibilities to honor them in diagnostic practice? What rhetorical possibilities might make such sensibilities accessible?

In a world where empirical observation shapes dominant epistemologies for understanding human experiences, prevailing interests in explaining all differences under the umbrella of health play a significant role in how mental health is conceived and treated. After reflecting on the historical accounts of how insanity immerged as a social construct, I invite Hanganu-Bresch to consider how Peter Conrad's notion of medicalization may inform and be informed by this discussion. Medicalization, according to Conrad (2013), is "the process by which previously nonmedical problems become defined and treated as medical problems, usually as diseases or disorders" (p. 196). As medical science has become increasingly specialized in its production of diagnostic terms, it seems that nearly any human behavior could be detected from a problematic view and deemed "abnormal." Furthermore, with the expansive access the general public has to sites such as WebMD and the like, it seems that the world has be-

come preconditioned to interpret all lived experiences through a medical lens. In fact, many websites provide symptom monitoring suggestions, risk assessments, and many other features that encourage citizens to look for potential problems and seek medical care. Hence, the medicalization of society, which Conrad addresses at length, demonstrates how diagnostic language in our modern time functions as a "terministic screen" (to borrow the authors' Burkian reference, p. 128), that has led to heightened problematizations of mental health. Consequently, it seems that this problem-centered paradigm leads to a question issued by the authors—who is not ill in some fashion (p. 137)? Or let us ask, what does it mean to be mentally well? I welcome the author to speak in response to this question in lieu of the historical backdrop provided in the book. How do we probe our rhetorical imaginations to initiate a wellness lens, one of appreciative inquiry (cite) into discursive negotiations about health?

I refrain from suggesting medicalization as "bad." Aligning with Conrad's (2013) observations, medicalization simply is, but the outcomes of its widespread appropriation can distort understandings of health by magnifying problems (p. 199) When something is identified with a medical diagnosis, it almost always comes with a deficient sort of connotation; that is, something that requires a supplement, treatment, or extra care. Furthermore, even when diagnosis is not present, dwelling on challenges that people experience with their mental health does not always open up possibilities for appreciating the remarkable qualities of the human mind that sustain life under difficult conditions. Many adaptations considered "abnormal" may in fact be "normal" responses to abnormal conditions. As such, I ask the author, how might we embrace a broader view that invites us to prioritize individuals' biographical experiences as well as their current circumstantial and social surroundings before scrutinizing individuals as the site where problems dwell? Might many mental health issues of our times be symptomatic of something beyond the individual? As Niklas Rose (1996) was quick to observe, locating problems within individuals leaves environmental and institutional issues in the dark, thus allowing many corrupt norms of society to persist. When adopting this critical view, it appears that we may be very well be "treating" healthy individuals to adjust to an unjust society, one that prioritizes efficiency, industrial endeavors and capital gains often at the expense of human livelihood. And when individuals do not align with these priorities and are confined as a result, how might this jurisdiction pose a greater danger to society by removing human indicators of a corrupt world? That is, if human affliction was viewed as a symptom of a sick environment, how might negotiations regarding diagnosis look different through this radical view? Such a view is encouraged by Michel Foucault (1965) who raised a critical eye towards the enabling and constraining power of institutionalization. I invite the author to speak further about how the observations they gleaned from the historical texts inform us about and may offer a different perspective on the current landscape of mental health. I realize I am asking for a response that ventures beyond the scope of the historical focus in the book; meanwhile, I believe the author may have compelling insights to offer regarding what history may teach us for future practice. Where do we—scholars, practitioners, and patients—go from here?

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