THE EPISTEMOLOGY OF THE PATHOLOGICAL:
ESSAYS ON MENTAL HEALTH FROM
PLATO TO FOUCAULT

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This project is in a broad way a culmination of what I consider the most interesting aspects of my graduate research and study at Oklahoma State University. The topic of mental health covers an extremely wide range of philosophical issues, from epistemology and philosophy of science to moral philosophy and applied ethics. Given this conjuncture of philosophical interest, it has not been difficult to identify areas of intersection, overlap, and congruence in which others are engaged philosophically. However in part because of this wide overlap of philosophical interest, it is imperative that one be sensitive and mindful in the treatment of a topic as philosophically fruitful as mental health.

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CHAPTER I

AN EPISTEMOLOGY OF PATHOLOGY

In his recent book *The Harmony of the Soul: Mental Health and Moral Virtue Reconsidered*, Neal Weiner reminds us that the roots of the word *psychiatry* simply mean the “healing of the soul”\(^1\). This fact is crucial for several reasons. First, it suggests that any inquiry into psychiatry and its history, origins, concepts and practices is at the same time an inquiry into the various healing techniques and practices of the soul. Secondly, it reminds us immediately of the dated origins of the philosophical, theological and moral aspects surrounding the historical notion of the soul. Thirdly, it reminds us of a certain tension and uneasiness that exists between the etymological associations of the word *psychiatry* just mentioned, and psychiatry *qua* psychiatry as a modern medical scientific practice. In other words, the word *psychiatry* itself already presents us with two seemingly conflicting views. On the one hand, modern psychiatrists and mental health physicians are professional medical practitioners whose work is informed by various branches of established medical science and research. And, on the other hand, any mention of psychiatry seems to simultaneously entail questions about the human *soul* – a concept which has a prominent historical definition dating back to at least Aristotle as that which is immaterial, transcendent, eternal, and thus immune or perhaps logically opposed to scientific inquiry or explanation.

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\(^1\) (Weiner 1993, 41)
This inherent ambiguity in the word *psychiatry* is in a broad way central to my thesis. The two senses of the word psychiatry mentioned above do not represent a merely semantic or etymological discrepancy. Rather the inherent ambivalence made apparent by these two distinct senses of *psychiatry* reflects a complex and intricate set of problems that surround not just the history of psychiatry itself, but a whole range of philosophical, historical, and socio-scientific issues. Such a rich and complex history of the development of this ambivalence is unfortunately not within the scope of my thesis. However since I am dealing, in a sense, with the history of madness and mental illness, the ambivalence surrounding psychiatry mentioned above will inevitably provide the background against which most of my arguments take stage. Thus, in order to make clear the background of my approach to the problem of madness and mental illness, I will briefly give an account of the these two distinct senses of “the healing of the soul” – what I call moral discourse and a scientific discourse of madness.

As I will argue in Section III, both a moral and a scientific discourse of the soul, and of madness in particular, have their conceptual foundations in Plato. Both in the *Timaeus* and the *Laws*, as well as in portions of the *Republic*, I argue that Plato gives us two distinct types of madness which make possible both a moral discourse of madness which is taken up as described by Weiner, and also a medical-scientific discourse of madness that is divorced from moral categorization. First I argue that a moral discourse of madness begins in Plato as a type of madness that is characterized by and associated with either virtue or vice. Thus at *Timaeus* 86b, Plato ends his discussion of the diseases of the body to begin a discussion of the diseases of the soul ‘which are due to the condition of the body’. According to this account, ‘folly’ is a disease of the soul that is
composed of two kinds: *madness* and *ignorance*. What we discover is that there is one form of madness due to excessive pain, and another which is due to excessive pleasure of intemperate actions. Thus there are two kinds of pathologies of madness: one which is physically caused, involuntary, and identifiable by reference to physiological pain and ‘harmful dysfunction’ (without the logical condition of a moral determination), and another which is also physically caused, involuntary, but whose identification necessarily entails the logical condition of a moral determination—namely the behavioral criteria which specify what is temperate and intemperate, moderate and excessive, ordered and disordered. I argue that even though in the *Timaeus* and *Laws*, Plato assimilates virtue and vice to health and disease in the literal sense, it does not necessarily follow that madness for Plato can be neatly characterized as either a virtue or a vice. Since these two pathologies of madness in Plato may be the origin of behavior that is either virtuous or vicious, as well as morally benign, there remains a form of madness which is morally ambivalent. Given this distinction between the two types of madness in the *Timaeus*, I argue that Plato maintains a conception of madness that is morally ambivalent, but whose explanation or identification does not entirely preclude a medical-scientific discourse.

Both Weiner and Foucault argue that such a moral discourse surrounding madness is taken up and continued up to the Enlightenment. Weiner observes that in modern times “…a semi-moral/semi-medical way of thinking about what the self ought to be has become dominant in many circles, and might well be said to constitute an original American contribution to popular ethics, the moral equivalent of jazz.” (Weiner 1993, 16)

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2 According to Jowett, for Plato, “…vice is due to physical causes (86D). In the *Timaeus*, as well as in the *Laws*, he also regards vices and crimes as simply involuntary; they are diseases analogous to the diseases of the body, and arising out of the same causes.” (Jowett, Benjamin, *Timaeus: Introduction and Analysis in Plato: Gorgias and Timaeus*. New York: Dover, p. 164)
This moral-medical conception of the self, according to Weiner, is in a revival of the traditional moral-medical model of the self that was dominant until the scientific revolution. Under this Platonic view of the self, medical concepts such as health and illness were inseparable from concepts of virtue and vice. “Historically speaking”, Weiner says, “the overwhelming likelihood, to judge from Greek moral philosophy and the medical practices of traditional peoples, is that the medical ‘model’ of the soul came first and that it took a great deal of philosophical effort to divorce health and goodness.” (Weiner 1993, 17) It was not until the scientific revolution, culminating in the Enlightenment “is/ought” distinction that the domain of morality was considered philosophically and conceptually separate from the domains of health and medicine (13). Thus for Weiner, it is only fairly recently that the moral discourse of mental health has been appropriated by a scientific discourse that attempted to separate the moral realm from the scientific/natural realm (17).

According to Weiner, problems arising from mental health and illness were traditionally conceived and spoken of in terms of moral virtue. He observes that “…in the traditional language of morality, deviations from psychological health are generally vices. This, in turn, means that health encompasses some rough form of virtue”, further contending that “the general structure of mental health and illness conforms to the general structure of virtue and vice as understood by Aristotle.” (Weiner 1993, 119) Indeed, until “the rise of the mechanical world-view”, he says, “virtually everyone believed” that issues relating to psychological health and illness were inseparable from and regulated by the moral domain (120). Now we do not have to regard as tenable Weiner’s contention (which he makes throughout the book) that the structure of mental
health and illness as we understand it today in fact conforms to Aristotle’s notion of virtue and vice in order for us to take seriously his historical observation concerning the moral foundations of a traditional and ancient view of psychological health. Indeed, Weiner traces out the moral foundations of psychological health from Plato and Aristotle to Aquinas, noting the continuity of a definite moral discourse that governs issues surrounding psychological health and illness. Thus for Weiner, the pre-Enlightenment discourse surrounding madness and mental health was conditioned by the notion of “the harmony of soul”, which saw health as virtue and its contrary as vice (Weiner 1993, 126).

For Foucault, madness in the pre-Enlightenment sense was also governed by a certain moral discourse. In the classical age of the Renaissance, madness for Foucault was characterized by a certain ‘critical consciousness’ which recognized and to some extent appreciated madness as an inimitable experience in the existence of man. Under this critical consciousness, madness ‘rubbed shoulders’ with reason (Foucault 2006, 45), “reminding everyone about the wafer thin borderline between reason and unreason” (Ljungdalh 2008, 72). The mad were thus conceived as a reminder of what possible forms human existence could take, or what one might be. Thus in Shakespeare's play, King Lear, and Cervantes' Don Quixote and other popular literary or artistic portrayals, madness appears as part and parcel of the spectrum of human experience. Therefore the classical treatment of madness for Foucault retains a morally and perhaps religiously significant discourse which conceived of madness as a part of human existence which signifies a “gateway between this and a mysterious other world.” (Ljungdalh 2008, 72)
However, with the rise of Enlightenment rationality (what Foucault refers to as ‘the classical period’), the conception and maintenance of madness takes on new and different forms. “(T)he transition from the Renaissance to the Classical Age”, Foucault argues, “reoriented the cognition of madness” (Ljungdalh 2008, 72) such that it was no longer able to speak of madness as ‘rubbing shoulders’ with reason. Under an Enlightenment conception, the dialectic nature of madness is replaced by the observing eye of Reason which places restraint and silence on the mad-man. For Foucault, madness is from this point “mingled in an equal guilt with unreason; madmen were caught in the great confinement of poverty and unemployment” (Foucault 1984, 150). The great confinement, a European movement of social organization exemplified by the infamous Edict of 1656, represents for Foucault the codification of madness and the mad into a category of moral and social disapproval. Thus institutions were created for the confinement of the mad, the poor, the idle and indigent, such as the General Hospital. “It was in these places of doomed and despised idleness”, Foucault writes, “…in this space invented by a society which had derived an ethical transcendence from the law of work, that madness would appear and soon expand until it had annexed them.” (Foucault 1984, 135) However Foucault makes clear that this perception of madness through a “condemnation of idleness” had not a merely economic or bourgeois function or origin. Rather, the great institutions of confinement in the pre-Enlightenment era were essentially moral institutions which were “responsible for punishing, for correcting a certain moral ‘abeyance’”, and which acted upon the origins of poverty “which were neither scarcity of commodities nor unemployment, but ‘the weakening of discipline and
the relaxation of morals’.” (Foucault 1984, 136-137). Indeed, unlike the ‘imaginary liberty’ that was allowed madness in the classical age of the renaissance where madness

“... was still visible in the light of day, as in King Lear or Don Quixote... within the space of half a century it found itself a recluse in the fortress of confinement, bound fast to Reason, to the rules of morality and their monotonous knights.” (Foucault 2006, 77)

Thus the great confinement of madness in the 17th century represents for Foucault the historical location and organization of madness into a moral discourse.

Thus for Foucault and Weiner, there is a distinct moral discourse of madness that prevails in the pre-Enlightenment or ‘classical’ period that is to be contrasted with a distinct scientific discourse of madness which develops in the Enlightenment (specifically for Foucault in the late nineteenth century). Beginning with the notion of psychological health and illness in Plato as a certain ‘harmony of the soul’ which treats health as virtue and illness as vice, we are able to trace a moral discourse of madness as a relatively distinct discourse up to its codification in the Edict of 1656: the organization of the mad within the moral institutions of the state. It is only until that period, as both Weiner and Foucault argue, that a separate and distinct discourse of madness is made possible, namely a scientific discourse of madness. For Weiner, it was the development of the mechanical world-view of science, coupled with the philosophical development of moral philosophy (culminating in Hume’s famous “is/ought” distinction\(^3\)) that made it possible for a truly scientific discourse to be elucidated alongside, or perhaps in place of, the traditional moral discourse of madness. For Weiner, this constituted an epistemological separation between virtue and health which he refers to as a “paradigm shift in moral psychology” (Weiner 1993, 12), one which is paralleled by Weiner with the theoretical

\(^3\) (Weiner 1993, 13)
advances of Kepler’s laws of planetary motion. Like Kepler’s laws, which were constructed to explain the apparent disorder of planetary phenomena rather than by appeal to the natural unity and order of the cosmos, so too was an entirely new theoretical device constructed in the attempt to explain the disorder of the human soul – in this case the moral philosophy of the scientific period, namely utilitarianism and deontology. This separation thus allowed a new form of *natural science*—including medicine and the domain of health—that operated at least conceptually independent from the domain of ethics in the form of moral rules, maxims and guidelines which one ought to follow. The result of this “paradigm shift” in moral psychology is a conception of the self divorced from the traditional Platonic idea of a healthy soul, a well-balanced and flourishing self whose full health entails moral virtue. Health and virtue, it would appear, were to part ways – the former into the increasingly bureaucratic and technical nature of the public health industry, and the latter in modern moral philosophy. Thus for Weiner, it could be said that the traditional Platonic moral discourse of madness and mental health, symbolized for Foucault in the Great Confinement of madness in 1656, became displaced in the Enlightenment by a medical-scientific discourse.

For Foucault, the story is much more complex. It is not the case, according to Foucault, that the traditional moral and religious discourse of madness ceased to have influence or came to a halt with its displacement by an Enlightenment medical-scientific discourse of madness. Rather, as Foucault shows, the scientific “capturing of madness” as mental illness in the eighteenth century is made possible through the moral-disciplinary practices developed out of the Enlightenment and then taken up in early psychiatry. Thus the ‘disciplinary regime’ of madness (Foucault 2006, 234) which is a product of the
Enlightenment begins to introduce a complex dialectic between itself and the more traditional discourse of madness previously couched in moral and religious terms. For Foucault, this complex dialectic between the moral discourse of madness and the moral-disciplinary regime of the Enlightenment makes possible the creation of a scientific discourse of madness centered around the notions of objectivity and neutrality (Foucault 1984, 164). Foucault shows how the ‘doomed and despised’ forms of idleness that were caught up in the great confinement – the poor, the indigent, the idle, the unemployed – were, in Foucault’s terms, eventually “annexed” by the expanding discourse of madness in the terms of the moral-disciplinary rationality of the Enlightenment. This moral-disciplinary ‘annexation’ of madness made possible the conditions under which a scientific discourse of madness could be elaborated beginning in the Enlightenment.

Thus one major thesis of Foucault’s lectures on *Psychiatric Power* is that the medical gaze of modern psychiatry—along with the objectification of mental health and illness—is dependent upon and made possible by the proliferation of ‘disciplinary power’ and its mechanisms of order and control. It is precisely the proliferation and ‘inheritance’ of the specific mechanisms of disciplinary power (which Foucault only later came to elaborate in such great detail in *Discipline and Punish*) which made possible the claims of objectivity and neutrality of psychiatric knowledge in the first place. Yet, as Foucault makes clear, there remains (perhaps most evidently at the present) a great tension between the conscious position that psychiatry once held through the development of its status as an instrument of social reform, and the subsequent ‘scientification’ of that status in the form of the positivist biomedical model of mental health. The reason for this, he makes clear, is that what once was seen as an explicit and conscious attempt at social
reform on behalf of the psychiatric establishment (in the wake of Pinel) becomes “overlain by the myths of positivism” (Foucault, 1984, 164), which assert a pure scientific objectivity over and above any reformative, moral or disciplinary pretensions. Indeed, what began from “a transparent and clear moral practice, (was) gradually forgotten as positivism imposed its myths of scientific objectivity” (164).

Thus for Foucault, we should understand psychiatric practice from this point as a “certain moral tactic” that is historically constituted and inherited from the disciplinary rationality of the ‘great reformers’ of the eighteenth century, yet whose moral and disciplinary intentions are eventually masked by the myths of scientific objectivity and neutrality. Mental health and illness therefore, even in as far as these concepts are products of a ‘positive’, objective and value-free knowledge, are concepts which nonetheless have been constituted in such a way that they would be incomprehensible without the moral-disciplinary conception upon which they were founded. This is the key to understanding Foucault’s approach to the concept of madness and mental illness – that is, what are the conditions under which an entire discourse of madness as mental illness is constituted which is conscious of itself as a form of positive knowledge, and objective knowledge at that? In short, Foucault’s conclusion to this question is that, “(If) the medical personage could isolate madness, it was not because he knew it, but because he mastered it; and what for positivism would be an image of objectivity was only the other side of this domination. “(Foucault, 1984, 160) Therefore for Foucault the study of mental pathology as an object of medical science was, from this moment in its history, an extension of the ‘disciplinary gaze’ masked by the myths of objectivity and neutrality.
Foucault makes the case that the ‘disciplinary regime’ of the Enlightenment appropriated the discourse of madness and exerted its influence through what Foucault calls “disciplinary power” – a term which first shows up in Foucault’s November 14, 1973 lecture which begins with an analysis of one of Pinel’s treatises on psychiatric treatment. Foucault, describing Pinel’s plight of ‘the king gone mad’, observes that the king’s madness is understood by Pinel as not under the authority of any sovereign or absolute power, but rather a completely different type of power…it is an anonymous, nameless and faceless power that is distributed between different persons. Above all, it is a power that is expressed through an implacable regulation that is not even formulated, since, basically, nothing is said, and the text actually says that all the agents of this power remain silent. The silence of regulation takes over, as it were, the empty place left by the king’s dethronement.4

And, shortly thereafter, Foucault says that in place of this “beheaded and dethroned power, an anonymous, multiple, pale, colorless power is installed, which is basically what I will call ‘disciplinary power’” (Foucault, 2006, 22). Thus for Foucault, the birth of what he calls ‘proto-psychiatry’ from 1820-1860 is consonant with the ‘capturing’ of madness through a discourse inherited from ‘the great reformers’5 – a discourse idealized in its “absolutely generalized social form” in the disciplinary mechanisms of Bentham’s Panopticon (Foucault, 2006, 41).

This disciplinary rationality is what Foucault claims in his course on Psychiatric Power that is the condition of possibility of objectivity and neutrality that is found in the modern medical gaze of psychiatry. For Foucault, the modern “medical gaze” of psychiatry refers to the place of objectification to which individuals are subjected by the

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4 (Foucault, 2006, 21)
4 “…from the beginning of the nineteenth century, the psychiatrist no longer quite knew what was the nature of the power he had inherited from the great reformers, and whose efficacy seemed so foreign to his idea of mental illness and to the practice of all other doctors.” (Foucault, 1984, 163)
establishment of the authority of medical knowledge. The ability of psychiatric knowledge to establish the objectivity, neutrality and legitimacy of its claims about mental health and illness is conditioned upon the establishment of a certain order, regulation and discipline within psychiatric practice. It is only within the confines of a disciplinary relationship that the values of psychiatric objectivity and neutrality are derived. Foucault shows in his course on *Psychiatric Power* that, for Pinel and his followers

(T)he condition of the medical gaze (regard medicale), of its neutrality, and the possibility of it gaining access to the object, in short, the effective condition of possibility of the relationship of objectivity, which is constitutive of medical knowledge and the criterion of its validity, is a relationship or order, a distribution of time, space and individuals. In actual fact, and I will come back to this elsewhere, we cannot even say of ‘individuals’; let’s just say a certain distribution of bodies, actions, behavior, and of discourses. It is in this well-ordered dispersion that we find the field on the basis of which something like the relationship of the medical gaze to its object, the relationship of objectivity, is possible- a relationship which appears as the effect of the first dispersion constituted by the disciplinary order…(T)he condition, therefore, of the relationship to the object and of the objectivity of medical knowledge, and the condition of the therapeutic process, are the same: disciplinary order. (Foucault 2006, 2-3)

This disciplinary relationship, exposed in Pinel’s treatise on the ‘king gone mad’, is what makes possible the conditions of stability and order, examination and observation. The objectivity of a value-free medical knowledge of madness, therefore, is made possible by the codification of this disciplinary relationship of the doctor-patient, observer-observed, and of the speaking and the silent. The second major claim of the lectures on *Psychiatric Power* is that, from roughly 1820-1860 psychiatry becomes a science of normal and abnormal behavior; that ‘abnormality’ becomes the condition of possibility of madness, where ‘madness’ is conceived of as an object of medical science. Psychiatry then becomes a type of power over abnormality that proceeds from the disciplinary gaze over abnormal behavior to a medical knowledge of madness. For Foucault this power over abnormality entails not only the observation and control of
madness, but rather “the power to define, control, and correct what is abnormal.”

(Foucault 2006, 221)

Viewing the birth of the discourse of madness in this way, we are much more able to understand the claims of Weiner (1993) and Foucault (1984, 2006) who each address the relationship between these two distinct discourses of madness. On the one hand, we are able to make sense of Weiner’s claim that the concept of mental health or well-being has traditionally been understood within a moral discourse about madness, beginning with the Platonic notion of the “harmony of the soul” (Weiner 1993, 17). Weiner claims that it is only recently (beginning with the scientific revolution culminating in the Enlightenment “is/ought” distinction) that the moral discourse of mental health has been appropriated by a scientific discourse that attempted to separate the moral realm from the scientific/natural realm (Weiner 17, 120).

Furthermore, this distinction helps us understand the importance of Foucault’s genealogical history of madness, and specifically his similar claim that a certain moral-disciplinary discourse of madness that characterized early psychiatry (Foucault, 2006, 2-3) eventually becomes “overlaid by the myths of positivism” (Foucault 1984, 164), creating a self-proclaimed scientific, objective and value-neutral discourse of madness. For Foucault, this discourse of madness effectively constituted the objective, scientific “capturing of madness” as mental illness in modern psychiatry. However, as Foucault argues in his lectures on *Psychiatric Power*, this new scientific discourse of madness failed to dissociate itself from the historical and conceptual foundations from which it arose – specifically the social and moral reformers of the 17th and 18th century⁶ - resulting in the distinction.

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⁵ In the course on *Psychiatric Power*, Foucault traces out the moral and disciplinary practices of Pinel, Tuke and other early psychiatrists by noting the intimate connection that the rationality of the asylum and its
in a nineteenth century medical knowledge of mental illness that knew not what it was: a medical-moral science of abnormality informed by disciplinary institutions, yet masked by the positivist myths of objectivity and neutrality. Thus for Foucault, the birth of modern psychiatry is consonant with the emergence of a study of madness as a science of abnormality (Foucault 2006, 220-221), one that is constituted by a moral-disciplinary discourse.

Thus for both Weiner and Foucault, we are justified in speaking about a moral discourse and a scientific discourse of madness, both of which have been taken up at different moments and have interacted with one another in different ways at different times. However, as Weiner argues, there has been a recent revival of the traditional discourse of the ‘healthy soul’, most evidenced by “the peculiar way that the language of virtue and the presupposition of the harmony of the soul has entered the semiscientific language of medicine”. (Weiner 1993, 15) This “semi-moral/semi-medical” conception of mental health has, according to Weiner, been a consistent theme within psychotherapy from the time of Jung, with psychologists and psychiatrists “making it either their explicit thesis or their more or less explicit presupposition” (15) Indeed, the new dominant ideal in the mental-health establishment is the concept of mental health from a semi-moral/semi-medical point of view. The concept of mental health that has been constituted by the rise of psychiatry has been

reshaping our moral thought as surely as if it had led a successful revolution. Indeed, there has been a revolution. It has already been noted how the language of medicine has partly displaced the language of morality. Matter of character- fastidiousness,

practices had with the disciplinary rationality of reformers like Jeremy Bentham, whose Panopticon is exemplified as a model for psychiatric discipline and order throughout the course lecture.
promiscuity, gluttony, addiction, ambition, etc – which used to be thought of as moral, are now routinely treated as medical problems….This is merely a change in vocabulary. Along with it has come a redrawing of the normative lines. What a previous generation saw as proper ambition is now a compulsion. What was once considered moral integrity, is now viewed as a pathological judgementality. The so-called sexual revolution was only the cutting edge of this general shift of values that might more properly be called “the therapeutic revolution” (Weiner 1993, 41-42)

This semi-moral/semi-medical view of mental health has been largely formed and shaped by what has been called the “two minds” of psychiatry – on the on hand, the psychotherapeutic model influenced by Freud, Jung, Adler and others which dominated early psychiatric practice in the United States in the 1950s, and on the other the biomedical model that dominates current practice, particularly in the United States. And although each of the two different models of psychiatric knowledge – the psychotherapeutic and the biomedical– have contributed in their own ways to our understanding of mental health, as Luhrmann notes in her book Of Two Minds, each model carries with it “different models of the person, different models of causation, and different expectations of how a person might change over time.” (Luhrmann 2000, 7)

Indeed, as Luhrmann points out, depending upon which model of mental health one adopts, one will come to understand psychiatry and its aims in a drastically different manner. “Psychiatry”, Luhrmann says, “is unquenchably compelling because it forever changes the way you understand human experience.” (Luhrmann 2000, 5) In her book, Luhrmann makes the case that that these two models - the psychodynamic and the biomedical-- serve as distinct “lenses” through which we see not only mental illness but human experience as a whole. “The real issue for me”, Luhrmann says, “is how one learns to look at mental illness through different lenses and the consequences of those ways of seeing.” (Luhrmann 2000, 10) In the last two decades, she says, the biomedical
model of psychiatry has become dominant in the United States which treats mental illness as bodily pathology that is more or less similar to physical illness. This model of mental health maintains a biological view of mental illness, prescribing medication and rest as primary therapies. It also is highly dependent upon scientific psychiatric research from the neurosciences and the pharmaceutical industry. In contrast, the psychodynamic model of mental health, which places emphasis on psychotherapy and psychoanalysis, views mental illness as “something much more complicated, something that involves the kind of person you are: your intentions, your loves and hates, your messy, complicated past.” (Luhrmann 2000, 6)

These two distinct “lenses” of psychiatry affect the way that both practitioners and the public in general view mental illness and the human experience. Each of these lenses contain very different sets of ideas and practices which shape the way we view mental illness and madness. Yet regardless of which psychiatric lens one views mental illness through, madness always seems to remain “both frighteningly, palpably present, and yet elusive.” (Luhrmann 2000, 10). First of all, there is no medical test for any specific pathology for any major psychiatric illness and, as Luhrmann suggests, “there is no reason to suppose-despite occasion claims to the contrary- that we will have any way to do so anytime soon.” (Luhrmann 2000, 20) Secondly, what is understood today as psychiatric illness involves so many evaluative factors in the etiology, identification, experience, and description of psychiatric problems that even the relatively new ‘biopsychosocial’ approach refers to too few factors. Indeed, “no matter how you slice the research, psychiatric problems involve genetic vulnerability, bodily stress, social milieu, cultural interpretation, family history, and individual temperament” (20), not to
mention the role that historical and cultural conditions play in the very experience and expression of madness or mental illness.

So although the ‘two minds’ of psychiatry have been determinate in our modern understanding of mental health, this understanding is one that in no way lacks any measure of ambiguity, uncertainty, or uneasiness concerning even some of its most central concepts, terms and categories. The mere fact that both the biomedical model and the psychodynamic model carry significantly different conceptions of the self should remind us just how difficult it might be from the outset to agree upon a definition of mental health that would be satisfactory to both models. However at the same time, there is a (mostly) accepted theoretical tool that is used today if we consider the standard that is used in contemporary mainstream psychiatry, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is described as the “standard reference work for pathology for the mental-health field” (Weiner 1993, 42) and “the world’s most utilized psychiatric reference” (Boysen 2007, 157) The DSM can be legitimately called the ‘bible’ of mainstream psychiatry in the United States, serving as the primary reference tool for all major psychiatric disorders. The most recent DSM-IV contains a total of 365 mental disorders which have their own distinct definitions, constituting the “guide to the behaviors that make up the concept of mental disorder.” (Boysen 2007, 157) And although the general aim of the DSM is to provide diagnostic criteria for clinical psychiatrists and mental health physicians working in the field, these criteria are neither used nor accepted by all practitioners. Furthermore, and perhaps partly because of this, many within and outside mainstream psychiatry have pointed out in great detail the
ambiguity, uncertainty and uneasiness that characterizes much of *DSM* categorization, language, definitions and concepts.

As Boysen (2007) has pointed out, the behaviors that are labeled as disordered in even the most recent *DSM-IV* cannot together represent a valid operational category because no operational definition of *disorder* is ever given. And even though“(F)orming an operational definition of mental disorder is legitimately difficult…the position taken in the DSM toward that task could be characterized as disinterested and defeatist.” (Boysen 2007, 159) This failure to provide a definition of mental disorder, to begin with, ignores the wide range of problems that arise in the analogy between mental and physical illness. This analogy fails in many respects, and the further one pushes the analogy, the more assumptions one makes about the nature of mental illness. For example, unlike physical illness which generally has an objective biological component, this is generally not the case with mental illness. In the majority of cases, there is no clear and identifiable biological component to the mental disorder in question. Secondly, the basic values which inform our concept of disorder in the mental domain involve an element of cultural and social import that the physical concept of disorder often lacks. Indeed, as Boysen points out,

“…the concept of mental illness is more susceptible to bias based on values than the concept of physical illness (Fulford, 1999; Widiger, 2002). Although the biomedical model values of life and freedom from pain are universal and evolutionarily based, values concerning behavior, cognition, and emotion are less agreed upon and are, therefore, less stable. As such, including a behavior in the DSM as a disorder sometimes involves the application of a cultural value that may change over a short period of time.” (Boysen 2007, 159)

Indeed we need not be reminded of the ‘dark days’ of institutional psychiatry and its appalling collusion and participation in the eugenics movement both in Europe and the
United States\(^7\). However, we cannot deny that we are barely 40 years removed from deinstitutionalization, barely 30 years removed from the inclusion of homosexuality as a certified psychiatric disorder\(^8\), barely 20 years removed from the widespread political abuse of psychiatric practice in the Soviet Union\(^9\), and now find ourselves currently in the midst of multiple controversies concerning the overtreatment, overdiagnosis, and safety risks of psychiatric drugs in American public schools and communities\(^10\) as well as the undue influence of pharmaceutical companies in psychiatric practice and drug prescription\(^11\). For Foucault, these instances would reflect much more than occasional lapses in proper psychiatric practice. Rather, such instances would be representative of the disciplinary nature of psychiatric practice and, furthermore, we should not be that surprised if such manifestations of psychiatric power often produce extreme consequences. Regardless, if this alleged moral-disciplinary nature of psychiatric practice can arguably be explained away as relatively minor to the overall status and legitimacy of modern psychiatric knowledge and practice, they nevertheless each point us to and remind us of one fundamental question which always seems to be staring us in the face:

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\(^7\) Breggin, Peter R. “Psychiatry’s Role in the Holocaust”. International Journal of Risk & Safety in Medicine, 4 (1993) 133-148


the question of *what it really means to say that one is mentally healthy or mentally ill.* These of course are no small concerns, and should give us pause as to how psychiatric knowledge and practice is used, how it is produced, and what its aims, methods and goals are.

Discussing the often moralistic aims and methods of psychiatric practice, Matthews (1995) says “(T)hat psychiatry has functioned in this moralistic way in all too many cases is surely undeniable”, going on to note the way in which homosexuality, masturbation, and political dissent has been included as a mental disorder within mainstream psychiatry. (Matthews 1995, 22) However, as he goes on to suggest, these cases do not _by themselves_ prove much at all about the nature of psychiatry and psychiatric practice. Rather, some case has to be made that shows that the practice of psychiatry _qua_ psychiatry is “in its very essence moralistic rather than therapeutic” (Matthews 1995, 23). According to Matthews, this task is best accomplished by Foucault and his genealogical strategy which attempts to show that “our modern concepts of scientific psychiatry and ‘mental illness’ are the products of a long historical development, and incorporate within themselves important residues of this history.” (23)

In this way, we can more clearly understand the meaning of psychiatry within our own cultural and historical context, and thus see how the present discourse of psychiatry is to some extent dependent upon and shaped by that very meaning.

Yet if Foucault is right about the historical and discursive formation of psychiatry, then we ought to expect at least some residue of that historical and discursive formation in modern psychiatric practice. We should find, in other words, underneath a rhetoric of observer-objectivity and value-neutrality, an implicit layer of moral and disciplinary
mechanisms which are in some sense foundational to the nature and functioning of psychiatric practice. We ought to discover, that is, the implicit operation of what Foucault leads us to believe is in reality a ‘science of abnormality’ beginning in the late 19th century to the present day, where abnormal behavior takes the form of moral or social transgression. At the minimum, we ought to be able to uncover and expose the ‘myths of objectivity and neutrality’ which effectively mask the moral-disciplinary character of psychiatric practice.

First, with regard to claims of observer-objectivity and value-neutrality in psychiatric practice, and in particular with regard to the diagnostic criterion of mental disorder found in the DSM, Charland suggests that there are a whole range of “normative assumptions, which are philosophically concealed by the neutral clinical descriptive language of the DSM.” (Charland 2006, 118) In his article *The Moral Nature of the DSM-IV Cluster B Personality Disorders*, Louis Charland argues that the Cluster B personality disorders defined in the DSM-IV, which include antisocial, borderline, histrionic and narcissistic personality types, are not clinically valid disorder categories – in fact they cannot even be called clinical disorders at all. In his examination of these Cluster B disorders, Charland concludes that, while perhaps empirically valid syndromes, these disorders in no way represent clinically valid syndromes. Thus, Charland refers to the Cluster B disorders as “moral disorders”, noting that their “moral character is an integral part of the conditions they are designed to capture”…and that this moral character “is not logically dispensable” for their very identification and diagnosis as disorders in the first place (Charland 2006, 119-120). Furthermore, the ‘clinical character’ of the Cluster B disorders are “totally unspecified”, meaning that “there is no
clinical reason or evidence to think that the Cluster B disorders are more than moral categories.” (120) The result of this is that there is no justification to consider Cluster B disorders as “subject to and amenable to clinical treatment or therapy.” (120) Charland goes on to mention others such as Eliot (1996) who seriously doubt the clinical nature of personality disorders more generally, noting that disorders such as these that are inseparable from the logically prior moral aspect of the disorder necessarily entail that “successful treatment in this case is tantamount to a moral conversion”. (Charland 2006, 122)

The claims of observer-objectivity and value-neutrality in psychiatry have been attacked on more philosophical grounds, as Bolton (2001) has pointed out. The entire project of psychiatric classification, diagnosis and clinical practice as reflected in the DSM clearly takes an exclusively medical model with regard to mental disorder. The result of this is that “there is apparently a background assumption in the whole enterprise that there is going to be a medical, objective basis to the norms in question.” (Bolton 2001, 188) The problem with this is that such an assumption has been vigorously attacked for some time now by philosophers, psychologists and those working within the mental health field. “The apparent observer-relativity of intentional states”, Bolton writes, “may suggest…that the norms which characterize them cannot be defined in non-relative, absolute terms. This line of thought poses a threat to the objectivity of a concept of mental disorder defined in terms of breakdown in intentionality alone.” (Bolton 2001, 188) The attribution of meaning to mental states, Bolton reminds us, is a project in which both clinical psychiatrists and those involved in the classification and defining of mental disorders are intimately involved. Drawing upon the work of both psychologists such as
Jaspers and philosophers such as Wittgenstein and Dennett, Bolton reminds us that it has been accepted for some time now that the project of attributing meaning to mental states “which can be regarded in this context as interdefinable with intentionality, involves subjectivity and empathy.” (187) This raises the important question:

Is it society that decides when there is order or disorder? Is it physicians? It is likely that the apparently innocuous term ‘clinically recognizable symptoms’ in the definitions of mental disorder in *DSM*4 and *ICD*, quoted above, in fact does a lot of work, suggesting that it is physicians, or ‘clinicians’, who are the arbiters of what is normal and what is not. (187)

These moral, cultural and philosophical factors that are intimately involved in the nature of psychiatric diagnosis, classification and practice that Boysen, Matthews, Charland, and Bolton have pointed out should be seen as evidence in support of Foucault’s contentions about psychiatry more generally. First, these examples show that the claims of observer-objectivity and value-neutrality in evaluating claims about mental health and illness can be likened to what Foucault called the “myths of objectivity and neutrality” that thematize modern psychiatry. Both in its historical development and in its contemporary practice, mainstream psychiatry cannot genuinely claim that the behaviors and disorders that have been codified in practice as being pathological are codified solely on the basis of a detached and objective analysis of mental illness which is devoid of subjective factors (cultural, political, social, commercial, etc). Neither can it genuinely claim that those behaviors and disorders that are codified in practice as being pathological are codified without any moral import. Indeed, if we accept the fact that clinical psychiatrists and practitioners are necessarily involved in the attribution of meaning to the mental states and observable symptoms of others, then it seems that we must accept the conclusion that modern psychiatric practice necessarily operates through
the subjective filters of its practitioners and authorities. If this is true, it would explain Charland’s conclusions about Cluster B personality disorders as defined in the DSM-IV. In other words, it would explain why Charland found that Cluster B disorders in the DSM-IV are in reality moral disorders in which moral evaluation and moral competence is *logically necessary* for the identification, diagnosis, categorization and even treatment of the DSM-IV Cluster B disorders.

Furthermore, we ought to appreciate Foucault’s insistence that psychiatric practice from the late 19th century ought to be characterized as a ‘science of abnormality’, where a medical-scientific discourse of madness appropriates and then objectifies the traditional moral discourse of madness. Foucault’s argument here, while apparently controversial and audacious on the surface, is nonetheless a point that is made over and over again concerning the medicalization of behavior in modern societies. Since the Enlightenment, Weiner says,

(F)or better or worse, the language of therapy has to a large extent taken over the language of virtue. Vices like gluttony and bullying are thought of as character disorders, and are commonly discussed though a semitechnical, quasimedical vocabulary. Gluttony becomes a compulsive eating disorder, with another disorder, anorexia, at the opposite extreme. Intemperance becomes symptomatic of the addictive personality. Excessively rigid temperaments are labeled ‘anal-sadistic’, and excessively compliant ones are called “oral-masochisitic’. (Weiner 1993, 15-16)

Likewise, discussing the medicalization of modern homelessness, Lyon-Callo remarks that“(C)onditions and behaviors ranging from sexual decision-making, depression, credit card debt, sexuality, drug use, gambling, weight problems, and teen pregnancy are increasingly portrayed in popular and scientific discourses as the results of pathology of disorders within particular bodies or the bodies of groups of people.” (Lyon-Callo 200, 331) Thus Foucault’s contention that the modern notion of ‘mental illness’ is a product of
a medical-scientific discourse of madness which appropriates the traditional moral
discourse of madness beginning in the 19th century should be seen as a plausible
hypothesis, even if only as an explanatory mechanism for the evidence just mentioned.

Therefore given this discursive background of madness and mental illness in its
conceptual and historical formation, I begin Section II by taking up the problem of
contemporary homelessness in the United States in relation to that discursive background
of madness. I attempt to frame the issue of homelessness in terms of the relationship
between the same moral and scientific discourses which have formed the historical
concept of madness. Hence my examination of homelessness in the United States will
trace out the ways in which the moral and scientific discourses which have shaped our
understanding of madness have correspondingly shaped our contemporary understanding
of homelessness in the United States. The primary text for my discussion of homelessness
and the moral and scientific discourses that have shaped our understanding of
homelessness is Kathleen Arnold’s *Homelessness, Citizenship and Identity: The
Uncanniness of Late Modernity* (SUNY Press 2004), in particular chapter four on
*Homelessness and Panopticism*, pp. 87-128.

In her book, Arnold shows how our current understanding of homelessness has
been shaped in a significant way by disciplinary practices and techniques which are
informed by both a moral and a medical-scientific discourse of madness. On the one
hand, Arnold makes the case that the historical pathologization of homelessness in the
United States has directly shaped our understanding, perception, and experience of
homelessness. Thus the historical emphasis on the mental pathologies of homelessness,
Arnold argues, is directly connected with the moral-disciplinary regime that has
historically constituted homelessness itself. In the case of modern homelessness, then, there is both a historically moral and a medical-scientific discourse that marks the disciplinary governance of modern homelessness in the United States.

On the other hand, the discourse of homelessness in the United States is one that has been particularly affected and shaped by the discourse of medicine in general and psychiatry in particular. Both historically and conceptually, the ‘problem’ of homelessness in the United States has always been partly conditioned by a certain medical rationality and terminology. Indeed, the insistence that ‘homelessness’ is an identifiable, objective, and describable ‘problem’ which demands a ‘remedy’ has remained a central feature of homelessness discourse throughout its historical development in the United States. Whether we are speaking of the 19th and early 20th century problem of vagrancy as ‘social parasitism’\(^\text{12}\) or more contemporary notions of the homeless as ‘urban blight’, the discourse of homelessness has always been significantly informed by a medical paradigm.\(^\text{13}\) Moreover, a basic assumption that has underpinned the discourse of homelessness in the United States is that homelessness is fundamentally a mental health issue. Indeed, with the rise of the public health industry of the 19th and 20th centuries, ‘vagrancy’ and ‘pauperism’ were said to be paradigm cases of mental disease or mental ‘degeneracy’\(^\text{14}\), in addition to being considered forms of social parasitism. This trend continues to the present discourse of homelessness, with the

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\(^\text{14}\) Dawson (1900)
emphasis on the pathologies, behaviors, medical statistics, and possible treatments of ‘homelessness’ that dominate the mainstream literature on homelessness. Even among some of the most prestigious circles of scientific investigation, homelessness is viewed precisely as a problem of medical science. In his recent book titled *It Ain’t Necessarily So*, Lewontin recounts an interview with Daniel Koshland, the editor of *Science* in which, “when asked why the Human Genome Project funds should not be given instead to the homeless, answered, ‘What these people don’t realize is that the homeless are impaired….Indeed, no group will benefit more from the application of human genetics.’” (Lewontin 2000, 165) The implication- made even more explicit elsewhere- is that homelessness is due mainly to mental pathology, and mental pathology is more or less reducible to genetics. Under this view, mental illness really is a ‘disease’ that ‘impairs’ much like physical disease, and it is the work of neuroscientists and geneticists which will provide the medical-scientific solutions and cures to such diseases. Thus mental health turns out to be the absence of mental pathology – those diseases of the mind which impair the brain in various ways. Here the concept of mental health, specifically mental illness, seems to appear as a truly objective, value-neutral term that is used by scientists to designate their object of study: the specific diseases of mental pathology, no more, no less.

The attempt to define ‘mental illness’ as simply ‘brain disease’ is admittedly saddled with difficulties. First, unlike physical illness which generally has an objective biological component, this is generally not the case with mental illness (Boysen 2007, 159). It is one thing to make the *normative* claim that mental illness should be thought of as a brain disease because there is some agreement among mental health professionals

\[15\text{ Arnold (2004, 116-122)}\]
that mental illness \textit{ought to be considered} as the result of brain disease. But it is quite another to claim that what we generally mean by ‘mental illness’ \textit{really is} the result of a brain disease. The latter is an empirical claim, whereas the former is a normative one. Since the biological component of the ‘brain disease’ which is supposed to define what we mean by ‘mental illness’ just isn’t there in most cases, the empirical claim is fairly weak. As for the normative claim – that we \textit{ought to consider} mental illness as a brain disease – we must consider the consequences of such a suggestion.

The attempt to provide an objective and presumably value-neutral definition of mental health negatively through the identification of mental pathology (brain disease) might be adequate, if only it did not leave out so much that we consider absolutely central to the meaning of ‘mental health’. After all, the state of our ‘mental lives’ is something we have come to consider as something very personal, subjective and perhaps even immune to strictly scientific models. Indeed in large part because of the influence of the lens of the therapeutic model of psychiatry, our understanding of the self and mental illness includes notions which resist essentially biological explanation. The content, exercise and execution of our own personal ‘mental lives’ seems to directly imply notions of intentionality, subjectivity, experience, choice, and will – notions which \textit{prima facie} resist scientific modeling and explanation. In order for us to \textit{consider} mental illness as simply brain disease, this would require us to conflate everything we generally mean by ‘the mental’ with essentially biological explanations. This would seem to include behaviors, actions, and habits of thought which meet the criteria for symptoms of a ‘mental illness’, thereby reducing such things to the level of biology. The problem with this is that a corresponding definition of mental health – a ‘healthy’ mental life – would
seem to have to be committed to specifying what exactly it is about a mental life that makes it healthy or not. For the Platonic tradition, one’s ‘mental health’ entailed that one’s intentions, choices and desires be properly and harmoniously inclined towards virtues such as goodness, justice and moderation. Yet today we have a difficult time attaching too much moral value to the concept of mental health, for the same reason that we do not (normally) associate most modern mental disorders with moral failings or moral degeneracy.

However, as both Weiner and Foucault argue (and as many have demonstrated), this is precisely where mainstream psychiatry stands today, for better or worse. Modern psychiatry simply is involved not only with questions about mental pathology but questions necessarily dealing with moral concerns as well - questions concerning the human soul. This implies that any claim concerning mental health will necessarily entail deeply ethical and moral questions and concerns. Thus to claim that homelessness is at base a medical-scientific problem, thereby implying that mental illness is a topic that is exhausted by a medical-scientific discourse, is to impose upon the problem of both homelessness and mental illness what Foucault called “the myths of objectivity and neutrality” that have come to mark the modern mental health industry. Those who deny either the ethical issues involved in modern psychiatric practice, or the moral discourse which has helped constitute it, run the risk of imposing the myths of scientific objectivity.

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16 Weiner makes the case for “a surprising, almost astonishing congruence of the modern idea of mental health and the classical ideal of virtue. For both there is an original harmony of pleasure and function, and for both of them this harmony is disrupted by a pain, the relief of which produces a distorting pleasure.” (Weiner 1993, 139)
and neutrality upon all issues that are affected by mental health, in particular the issue of modern homelessness.

Perhaps without contradiction, our modern notion of ‘mental health’ seems to include both the proposition that ‘mental health’ is a property of minds that can be both objectively studied and achieved through observation and elimination of mental pathology, and the proposition that ‘mental health’ refers to a more qualitative, subjective and normative description of an individual’s harmonious relationship to himself and the world. Since this ambivalent notion of mental health and the various concepts related to it have been so influential in our understanding of homelessness in the United States, I will begin by examining the ways in which this ambivalent nature of ‘mental health’ is operative in the contemporary discourse of homelessness. Like Foucault, I wish to draw out the discursive formation of the problem of homelessness as it has been shaped and made intelligible by these two discourses of madness: one a moral, and one a medical-scientific discourse. Section II attempts this with the aid of Kathleen Arnold’s book on homelessness and panopticism, tracing out both the moral and scientific discourses and practices which have shaped homelessness in the United States. Then in Section III, I argue that there are two distinct types of madness that can be found in Plato, and that these correspond to two distinct discourses of the soul which Plato made possible. Then I show how this conceptual foundation made it possible for madness to become an object of both a moral and scientific discourse.
CHAPTER II

THE DISCOURSE OF HOMELESSNESS

In this section, I examine the claim that our understanding of modern homelessness has been significantly shaped by a medical-scientific discourse of madness, or mental illness. I argue that a medical-scientific discourse of mental illness, which is exemplified by the biomedical model that has dominated mainstream psychiatry in the last two decades, has significantly shaped our contemporary understanding of homelessness. Developments in medical psychiatry, neurology and the neurosciences have increasingly situated mental pathology and mental disorders under the rubric of scientific investigation and discovery. Here the major “background assumptions” of observer-objectivity and value-neutrality are preserved under the framework of biological psychiatry, uncovering the biological bases of psychiatric illnesses. In addition, the vast proliferation of studies and literature concerning mental illness and homelessness leads one to believe that homelessness is at base a mental health issue and that it is a problem that can be solved by medical science. In spite of the dominance of the medical-scientific discourse of the ‘homeless mentally ill’, and drawing upon research which counters this dominant image, I argue that the major mental disorders attributed to the homeless are precisely those mental disorders which are moral and not clinical in nature. I argue that since anti social personality disorder (ASPD) is the most prevalent mental disorder found
among homeless populations, and since ASPD and other related personality disorders are moral and not clinical in nature, the most prevalent disorders most prevalently found among the homeless are ‘moral disorders’ rather than clinically valid syndromes. My argument is further supported by the observation that prevalence of rates of ASPD among the homeless are inflated due to an inherent diagnostic bias involved in the medicalization of typical homeless behaviors. This shows, I argue, that there exists both a definite observer-relativity and crucial moral component in the diagnosis, examination and treatment of the ‘homeless mentally ill’.

In her book *Homelessness, Citizenship and Identity* (2004), Kathleen Arnold documents the historical development of homelessness and homeless policy in the United States beginning at the turn of the 20th century. Her main thesis is that the dominant image of the homeless today is one that has been historically formed through different moral, economic and scientific discourses, and misconstrues and simplifies a more complex reality. The predominant paradigm of the homeless that arises from the mainstream literature on the subject as well as in the media and public policy is, Arnold argues, one which overwhelmingly portrays homelessness as pathological deviancy. “(T)his paradigmatic view of the ‘bad’ -that is undeserving, pathological, and irresponsible- homeless”, Arnold says, “has been constructed through narrow definitions of home, rationality and citizenship.” (Arnold 2004, 89) A large part of this definitive construction of homelessness, Arnold argues, is the transformation that the discourse of homelessness takes around the middle of the 20th century. As she tries to show, the discourse and public attitude towards the homeless prior to the 1940s and 1950s was mostly “moralistic and disdainful”, viewing the homeless primarily as deviant or
immoral. (Arnold 2004, 107) This moralistic image, however, “has been transformed in more recent times into government intervention, increased bureaucratic contact and the development of a scientific body of literature examining their pathologies.” (107) This remains true to the present day, such that “(L)iterature about the homeless has mostly served to increase the body of knowledge of the pathologies of the homeless, whatever the intentions of the author.” (Arnold 2004, 120) As a result of this, the mainstream literature, media, and public policy all serve to construct a paradigm of homelessness which portrays “the politicoeconomic Other as lazy, conniving, pathological and irresponsible.” (104)

Arnold argues that since the 1940s and 1950s, a medical-scientific discourse of ‘the homeless mentally ill’ has become the dominant way of speaking about homelessness in the United States. The reason for this, I claim, is that modern homelessness has been significantly shaped by a strictly medical-scientific discourse of mental illness, exemplified by the rise to prominence of the biomedical model of psychiatry of the last two decades. Indeed by 1986, the American Psychiatric Association had already formed a ‘Task Force on the Homeless Mentally Ill’, concluding after several comprehensive studies on the subject that “(T)he homeless mentally ill have become one of the greatest problems of present-day society”.\(^\text{17}\) And since the answer to the question *Is Homelessness a Mental Health Problem?* was seen by many at the time to be clearly in the affirmative\(^\text{18}\), the problem of homelessness was then situated as a problem to be dealt with by mainstream psychiatry. Thus Bassuk et al, documenting psychological illnesses


in the “vast majority” of a sample of homeless men, women and children, conclude that homeless shelters “have become alternative institutions to meet the needs of mentally ill people who are no longer cared for by departments of mental health.” (Bassuk 1984, 1546)

This emphasis on the ‘homeless mentally ill’ and homeless institutions as the new mental health facilities of today has paralleled the rise to prominence of the biomedical model of psychiatry in the last two decades. As Boysen (2007) reminds us, “…psychiatry has been especially important in promoting and utilizing the biological approach” (Boysen 2007, 161), noting how the resurgence of the biomedical model of mental illness has its roots in nineteenth-century biological models of mental illness. Indeed, recent advances in the neurosciences have spurred on the movement to finally and fully integrate psychiatry into the framework of modern neuroscience, reducing psychiatric illnesses and disorders to a matter of neurology. The disciplines of neurology and psychiatry, it is argued, are separated by “arbitrary and counter-productive” barriers; they are both “moving closer together in the tools they use, the questions they ask, and the theoretical frameworks they employ”, and “(F)urther progress in understanding brain diseases and behavior demands fuller collaboration and integration in these fields.” (Martin 2002, 695) Under this framework, the high rates of mental disorders documented in homeless populations (see Figure 1) are seen as a matter of mental pathology which can be studied medically and, presumably, cured through scientific discovery. In fact, it has already been suggested that the high rates of psychiatric illnesses in homeless populations are due to neurological illness, and that this neurological illness is brought on by a bacterial infection. It is claimed that a genus of bacteria known as Bartonella which
is known to cause neurological disorders is the cause of psychiatric illnesses as well. In one study attempting to associate the *Bartonella* infection with psychiatric illness, the authors state that “…we hope to raise the possibility that patients infected with *Bartonella* can have a variety of mental health symptoms, continuing that “(S)ince *Bartonella* can clearly cause neurologic disorders, we feel the presence of psychiatric disorders is a reasonable expectation.” If the authors are right, then the problem of mental pathology also becomes a concern of public health and hygiene. And, as it is widely studied, homeless populations are at a very high risk of bacterial infection due to poor health and hygiene. In fact, there is a significant body of literature now which focuses exclusively on the incidence of *Bartonella* outbreaks in homeless populations. Thus, if homelessness is a mental health problem, and mental health problems are reducible to mental pathology, and mental pathology is reducible to neurological illness, and neurological illness is furthermore reducible to bacterial infection, then it follows that homelessness is a problem reducible to health and hygiene. Or, as Daniel Koshland, the former editor of *Nature* suggested, neurological illness is more or less reducible to genetics, and hence homelessness is a problem to be resolved due to the success of the Human Genome Project (Lewontin 2000, 165). In this way, homelessness is seen as a problem of genetic vulnerability to specific mental pathologies and disorders, such that if we can gain an understanding of the genetic factors in the acquisition of and vulnerability

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19 Of course, the odd part of this study is the explicit admission upfront that, “(T)he authors are not reporting that these patients offer certain proof of *Bartonella* infection”. Rather, the study only purports to “hope to raise the possibility that” there is some causal association between *Bartonella* infections and psychiatric illness.”


to mental disorders, we will have greatly advanced our knowledge of how to address the homeless problem.

The contemporary medical-scientific discourse of the ‘homeless mentally ill’ is preceded, Arnold shows, by the both public and academic attention upon the pathologies of the homeless in the 1960s and 1970s. This research on mental pathology of homelessness can be traced back to the 1940s when the homeless as a fairly autonomous group began to lose their sense of community. According to Arnold, this was due to “increased government intervention and urban renewal, and indirectly as a consequence of the increasing focus on the pathologies of the homeless.” (Arnold 2004, 91) And, despite contradictory evidence that suggested otherwise, research on the pathologies of the homeless focused on the association of homelessness with mental illness, drug addiction, alcoholism and criminal activity (91). This emphasis on the pathologies of the homeless in the 1940s, Arnold argues, is further preceded in the 1920s and 1930s by the organization and treatment of the homeless in connection to “the idea of morality, elimination of poverty, and the application of scientific solutions to social problems.” (Arnold 2004, 91) In this period, a distinction was made, she says, between the “new homeless” who were seen as blameless on account of the Great Depression, and the “old homeless” who were viewed as “moral degenerates.” (91) Thus a particular image of the homeless was, Arnold argues, formed and shaped over the last century by a distinctly medical-scientific discourse of homelessness, with its primary emphasis on mental pathology and deviant behavior. However, a true body of literature that focused upon mental pathology as an explanatory mechanism of homelessness did not fully appear until the 1940s. Prior to that time, Arnold says, the unhoused poor and “vagrants” were
generally characterized in the mainstream as either “moral degenerates” (in the 1920s and 1930s) or as simply deviant or immoral (1900-1920).

In this way, Arnold argues, the contemporary discourse of homelessness has been shaped in a significant way by a medical-scientific discourse focusing on mental pathology. Indeed, the contemporary developments in medical psychiatry, neurology and neuroscience are such that mental pathology and mental disorders have increasingly come under the rubric of scientific investigation and discovery. Here the major “background assumptions” of observer-objectivity and value-neutrality are preserved under the framework of neurology, uncovering the biological bases of psychiatric illnesses. As Luhrmann shows, this biomedical model of mental illness become the dominant lens of mainstream psychiatry within the last two decades. Yet the historical emphasis upon mental pathologies of the homeless in the United States, as Arnold has shown, neatly parallels the rise to popularity of psychiatric practice in the United States.

In particular, the vast proliferation of research done on the mental pathologies of the homeless since the 1950s, and especially since the 1980s, has almost precisely paralleled the rise to prominence of the biomedical model of psychiatry over its Freudian psychodynamic predecessor. As Luhrmann notes in her book, “(T)he emerging school of ‘scientific’ or ‘remedicalized’ psychiatry” - which became dominant in the 1980s - was made possible by the early research conducted by “the new psychiatric scientists” of the 1950s (Luhrmann 2000, 226). These new psychiatric scientists, who began their research in the 1950s, are sometimes referred to as the “Neo-Kraepelinians” after the work of the German psychiatrist Kraepelin who is seen as the founder of modern scientific psychiatry. Working under the framework of biology and neurology, these scientific psychiatrists
operate under the idea “…that mental illnesses are discrete biological entities best treated medically as sicknesses (Blasfield, 1984)” [Boysen 2007, 161] These psychiatrists were highly influential in the development of the DSM-III which was published in 1980, which was the first edition of the DSM to be taken seriously in the field (Luhrmann 2000, 227). This streamlined, technical - and most importantly scientific – tool quickly became the most widely used and respected resource for psychiatric disorders, their definitions and their diagnoses. Indeed, the most comprehensive studies of mental illness among the homeless were not conducted until the mid-to-late 1980s (see Figure 1), several years after the American Psychiatric Association’s (APA) publication of the DSM-III in 1980. In essence, the biomedical model of psychiatry, and its potential for streamlining psychiatric research and practice, had finally been codified by the publication of the DSM-III. It was not long after this that the APA formed its ‘Task Force on the Homeless Mentally Ill’ in order to deal with what it considered “one of the greatest problems of present-day society.” This is yet another indication that our contemporary understanding of modern homelessness has been significantly shaped by a medical-scientific discourse of madness. Yet the question remains as to what the effects of this discursive formation of homelessness are.

Precisely how, and with what effect, has a medical-scientific discourse of homelessness been shaped and formed by the biomedical model of psychiatry? I attempt to show that there exists a diagnostic bias in the formulation of criteria for ASPD, which is the most prevalent disorder found among homeless populations. This diagnostic bias results in the inflating of prevalence rates of ASPD in homeless populations, thus incorrectly attributing mental disorders to a large segment of the homeless. Following
Charland and others, I argue that the dominant mental disorders that are most often found in homeless populations, in particular ASPD, are precisely those disorders which are moral and not clinical in nature. The reason for this, I argue, is that the biomedical model of psychiatry is overlain with what Foucault called ‘the myths of objectivity and neutrality’. These myths have been largely exposed in the ‘neutral, clinical descriptive language’ of the DSM (Charland 2004), and in the way that psychiatric practitioners are involved in the attribution of meaning to mental states. Both of these factors, along with Foucault’s own genealogy of psychiatry, show that there is an indispensably moral and subjective character to the nature of modern psychiatric classification, diagnosis and clinical practice. I conclude that the dominant disorders which are most often found among the homeless – antisocial and other personality disorders – are disorders that logically require a subjectively moral component for their very identification, diagnosis and cure.

In a study which compared a sample of homeless outpatient mental health clinic attendees with their housed counterparts in the same clinic, North et al (1997) found that, first of all, “(R)ates of schizophrenia, bipolar disorder, and somatization disorder were not significantly different between homeless and nonhomeless groups.” (p. 236) And while homeless men and women were found more likely to qualify for a diagnosis of alcohol use disorder and drug use disorder, respectively, they found that “(B)oth homeless men and women were significantly more likely than their domiciled counterparts to meet criteria for antisocial personality disorder.” (236) In addition, the same data were collected from a sample of non-clinic attending homeless from the same city as the clinic, and it was concluded that both groups were “demographically and
diagnostically very similar” to each other, with one exception. The only diagnosis that was more prevalent in the clinic-attending homeless sample was antisocial personality disorder. (236) The authors conclude by suggesting that “(C)linicians treating homeless outpatients may benefit from having special facility in diagnosis and management of antisocial personality disorder” in homeless populations. (236) In other words, the authors suggest that clinicians who deal with homeless populations have special training and competence in dealing with the mental disorder which is found to be most prevalent among homeless populations: antisocial personality disorder.

These findings are supported by Mueser et al (2006), who compared the characteristics of 178 dual-mental disorder clients in two separate urban areas. Their study separated out four different groups: one with no history of Conduct Disorder (CD) or Anti Social Personality Disorder (ASPD), one with CD only, one with adult ASPD only, and one with Full ASPD. Their findings suggest that those in the adult ASPD group “…tended to have the most severe drug abuse severity, the most extensive homelessness, and the most lifetime sexual partners”. In addition, both the full ASPD and adult ASPD groups were found most likely to have been homeless. The authors go so far as to say that “(I)n clients with dual disorders, homelessness appears to be a by-product of an anti-social lifestyle.” (Mueser, 2006, 1) Furthermore, they conclude that “homelessness may be associated with an anti-social lifestyle, even in the absence of a history of CD”. (1)

Fischer and Breakey (1991), discussing the high prevalence of personality disorders, and ASPD in particular, among homeless populations, make several important points. They point out some methodological problems that are involved in studying homelessness in connection with personality disorders. First of all they state that “(T)he
methodological problems of defining personality traits or disorders in a survey situation that generally only permits one brief encounter with a subject are formidable.” (Fischer & Breakey 1991, 1124) Second, and more importantly, they make the point that, “(I)t is possible that features of the homeless condition may mimic symptoms of personality disorder, particularly antisocial personality disorder, for which homelessness is a criterion for differential diagnosis, thus inflating prevalence estimates.” (1124) Here the authors suggest that there is reason to believe that the rates of antisocial personality disorder reported among the homeless might very well be inflated to due to the fact that the characteristics of homelessness itself are included in the criterion of the diagnosis itself. If true, this would mean that, in the diagnostic process of ASPD, it is presupposed that certain features of the homeless experience are themselves symptoms of the disorder. The authors then immediately mention a study which tested this hypothesis by eliminating from the diagnostic process of ASPD those criteria which would most likely be influenced by a subjects being homeless. In this way, the study was essentially testing whether the mere fact of being homeless was itself a central criterion of being diagnosed with antisocial personality disorder – a fairly serious diagnostic bias.

Interestingly, Fischer and Breakey report that the study showed that controlling for this diagnostic bias reduced prevalence rates from nearly one third to one fifth. These conclusions are reported without any comment of their significance or implication. However, if one takes the estimates of homelessness in the United States seriously at about 3.5 million, these conclusions become quite interesting. This means that, when controlling for the diagnostic bias involved in the “mimicking of symptoms” of the disorder with normal features of the homeless condition, prevalence rates of antisocial
personality disorder are reduced by 20 percent. This means that, instead of a projection of one third of homeless having ASPD, a figure of about 1.17 million, the figure becomes one fifth, or 700,000. Therefore, controlling for this diagnostic bias, this means that almost half a million homeless are incorrectly projected to have ASPD.

An objection might be raised that what I am calling ‘normal conditions’ of being homeless are in fact not so normal after all, and that no justification is given which distinguishes these ‘normal features’ of homelessness from legitimate symptoms of mental illness. If one does not assume from the beginning that the primary cause of homelessness is mental illness, then the question is open as to how to view the behaviors, actions, habits and ‘coping strategies’ of the homeless. Of course if it is believed that homelessness is due to mental illness, then one will inevitably view such behaviors as pathological and symptomatic of mental illness. However if one begins with this assumption, and then concludes that some features of being homeless do in fact mimic symptoms of mental illness after all, then one is simply begging the question. What needs to be shown, it is argued, is that certain features of homeless behavior are in fact symptoms of clinically valid mental disorders.

Yet this is precisely the problem – even in the clinical diagnoses of disorders among the homeless, there is a significant bias in interpreting certain features of homeless behavior – behavior that is often necessary for survival and dealing with life on the street - as symptoms of mental illness. As Fischer and Breakey put it,

(T)he protective effects of bizarre or hostile behavior may be lost sight of in focusing on pathology. A similar criticism is made on occasion, that what is identified by clinically oriented research as evidence of illness may in fact be adaptive or understandable in the context of life on the street or in a homeless shelter.

(Fischer and Breakey, 1991, 124)
One particularly striking example of this comes from a personal experience I had with a homeless individual named Robert. Every time I saw Robert, he was always carrying around large sacks, and he would indiscriminately stuff these sacks with wads and wads of newspapers. My friends and I began serving free weekly hot meals on the local courthouse lawn for the general public, and every week Robert would show up with his large sacks of newspapers. Of course for most of us, our first intuition was that he had ‘mental problems’, and that this explained his obsessive hoarding and collecting of newspapers with no determinate order, purpose or use other than to fulfill his unique neuroses. After several weeks of talking to Robert, it became clear that his obsessive hoarding of newspapers in large sacks was a behavior that was quite the opposite of what any of us had imagined, and was something that perhaps should have been obvious to any one of us. The large sacks with newspapers stuffed in them were simply Robert’s bedding. Needless to say, I felt a bit embarrassed and a bit ashamed that I had interpreted Robert’s behavior exactly like I would have interpreted the behavior of someone I knew beforehand was mentally ill. Indeed, it never even occurred to most of us that such behavior might in fact have a rational and so fundamentally basic purpose. And even though such experiences do not occur in a clinical setting, I think it aptly illustrates the dominant mindset that operates both in public perceptions of the homeless, as well as in a clinical setting.

Thus I argue that it is fair to say that a large number of homeless are incorrectly projected to have a personality disorder due to the diagnostic bias involved in the formulation of criteria for ASPD, and perhaps mental illness more generally. As the authors of the study suggest, normal features of the homeless condition are being
included as criteria for diagnosing ASPD, thus presupposing in the diagnostic process that the homeless suffer from symptoms of the disorder in the first place. In this way, I argue, normal features of the homeless experience are being medicalized as symptoms of a personality disorders without sufficient clinical or scientific justification. The reason for this, I argue, is that the disorders most widely found among the homeless are moral and not clinical in nature. Following the work of Charland and others, it should become clear that there is an indispensably moral and subjective component implicated in the identification and diagnosis of the most prevalent mental disorders that are found among homeless in the United States.

As I showed in Section I, Charland uncovers the moral nature of Cluster B personality disorders as they are described in the ‘neutral clinical descriptive language’ of the DSM-IV. Charland argues that these disorders which include antisocial, borderline, histrionic and narcissistic personality types, are not clinically valid disorder categories – in fact they cannot even be called clinical disorders at all. While perhaps empirically valid syndromes, Charland refers to the Cluster B disorders as “moral disorders”, noting that their “moral character is an integral part of the conditions they are designed to capture”…and that this moral character “is not logically dispensable” for their very identification and diagnosis as disorders in the first place (Charland 2006, 119-120). Furthermore, the ‘clinical character’ of the Cluster B disorders are “totally unspecified”, meaning that “there is no clinical reason or evidence to think that the Cluster B disorders are more than moral categories.” (120) The result of this is that there is no justification to consider Cluster B disorders as “subject to and amenable to clinical treatment or therapy.” (120)
Now if it is true that the identification, diagnosis and treatment of Cluster B disorders entails the logical condition of a moral determination, two responses are possible. First we could say that the identification, diagnosis and treatment of most if not all clinically valid disorders entails moral determinations and reliance upon moral categories for categorizing different behaviors. This response would admit outright the intrinsic moral nature of psychiatric classification, diagnosis and treatment. We would be admitting, in other words, not only that appeals to moral categories do not undermine the validity of clinical practice and research but that such appeals are often necessary to make clinical practice and research possible in the first place. Secondly, we could concede with Charland that Cluster B disorders are not clinically valid and that they are better conceived as ‘moral disorders’. It should be noted that the latter response seems to already presuppose a certain distinction between the ‘clinical’ and the ‘moral’. The distinction between the ‘clinical’ and the ‘moral’, it would seem, goes as follows: the knowledge that is applied in a clinical setting is theoretically independent from the moral categories and moral determinations of practitioners and clinicians themselves. Thus if a disorder is not “clinically recognizable”, this means that the disorder falls outside the knowledge base intended for clinical application; that is, the identification or diagnosis of the disorder in question depends upon factors external to the knowledge intended for clinical settings, such as moral categories. Charland, in his presentation of Cluster B types, appears to have just this distinction in mind. But whether we accept this clinical-moral distinction, or reject it on the grounds that most if not all clinical judgments involve a necessary moral component, we are still faced with the question of why Cluster
B disorders and their identification, diagnosis and treatment have such a fundamentally moral character.

If it is true that ASPD is the most prevalent mental disorder found among homeless populations, and that ASPD is not clinical but moral in nature, then it follows that the most prevalent mental disorder found among the homeless is one which is not clinically valid but rather moral in nature. This conclusion might help to explain why there is a significant diagnostic bias in estimating prevalence rates of ASPD among homeless populations. Such a diagnostic bias arises, the authors show, from the fact that normal features of the homeless condition are presupposed as symptoms of the disorder itself, meaning that normal features of being homeless are themselves counted as criteria of the diagnosis. As a result, prevalence rates of ASPD among homeless populations are significantly inflated. Thus one possible explanation of why such a diagnostic bias occurs is that normal features of the homeless experience are being medicalized as symptoms of a clinical disorder which in reality are not clinically valid at all, but rather common features of being homeless which are seen as morally and socially abnormal or deviant. This would also explain why the criteria for diagnosis of ASPD seems to include basic or elementary features of homelessness, where the experience of being homeless is itself synonymous with “mimicking the symptoms” of ASPD.

The hypothesis that prevalence rates of ASPD among the homeless are inflated due to the medicalization of behavior that is not clinical but moral in nature is consistent with the research of Snow et al (1986; 1988) who argue that the prevalence of mental illness among the homeless has been significantly overstated. In their sample, they found that approximately 16 percent had contact with the mental health system at the state or
local level and that “only 10 percent (had) been institutionalized one or more times.

Moreover, the greatest proportion of the contacts, according to the system’s standard diagnostic criteria, has been for substance abuse, primarily for alcohol, rather than purely for psychiatric problems.” (Snow et al 1986, 419) Comparing their findings to the ‘presumed’ relationship between homelessness and mental illness - estimates which range from 25 to 90 percent depending on severity - the authors say that “we are confronted with the intriguing question of how this difference might be explained.” (419) They then go on to say that this disparity, along with the dominant image of the homeless as mentally ill, can be attributed to four ‘interconnected’ factors:

1) unwarranted emphasis on the causal role of deinstitutionalization
2) the medicalization of the homeless problem
3) the greater visibility of the homeless mentally ill vis-à-vis the non-impaired homeless
4) the questionable procedures generally used to assess the mental status of the homeless

(Snow et al, 1986, 419)

Regarding the second factor, the medicalization of the homeless problem, the authors go on to describe the consequences that follow when a social problem is medicalized.

“(F)irst”, the authors state, “the medical profession becomes the major source of expertise, functioning to define in large measure the nature and parameters of the problem.” (Snow et al, 1986, 420) Secondly, it is stated that the problem is “framed from the standpoint of the medical model such that it is both individualized and depoliticized.” And thirdly, “…this perspective “frequently comes to function as the screen through which the problem is viewed and debated publicly”. (420) The authors then conclude by saying that

Each of these tendencies seems to be readily apparent with respect to the current wave of homelessness. The problem seems to have been defined in part in medical terms, as the bulk of the research linking mental illness and homelessness has been conducted by the
psychiatric branch of the medical profession (see Arce and Vergare, 1984; Bassuk, 1984; Lamb, 1984).

[Snow et al, 1986, 420]

These conclusions regarding homelessness and mental illness are echoed throughout Arnold’s chapter on homelessness and panopticism (Arnold 2004, 87-128), in which she often refers to the dominant image of the ‘homeless mentally ill’ as one which has been historically “constructed” through the medical-scientific emphasis on mental pathology\(^{23}\). In addition, Allen (1994) echoes the point about the medical field becoming the domain of authority on the subject of homelessness, saying that “…virtually all of the work is written by medical professionals, psychologists, and psychiatrists, the ‘experts’ in this new field” (Allen 1994, 183) However, as Snow et al make clear, this is not to deny that “there is a disturbingly significant number of impaired and dysfunctional individuals among the homeless”. (Snow et al, 1986, 421) What both Arnold and Snow et al are claiming, on the other hand, is that the image of the psychiatrically impaired homeless individual is not the most common one on the street. Thus these authors argue that “…there is enough research to undermine the presupposition that homelessness is an individual, and thus apolitical, phenomenon” (Arnold, 2004, 90), and that “the modal type among the homeless is a psychiatrically non-impaired individual trapped in a cycle of low-paying, dead-end jobs which fail to provide the financial wherewithal to get off and stay off the streets.” (Snow et al 1986, 421)\(^{24}\)

\(^{23}\) For a nice account of the “construction” of homelessness in the late 1970s and early 1980s as a medical problem, see Bogard (2001). She refers to this construction as “oppressive othering…the process by which “homeless people were defined as deficient and pathological, making their unequal treatment justifiable.” (Bogard, 2001, 426)

\(^{24}\) Some of these same conclusions are reached by Lyon-Callo (2000), Mathieu (1993), Allen (1994), and others
If Arnold, Snow et al and others are correct in their contention that the prevalence of mental illness among the homeless is significantly overstated, and that this is due in part to the medicalized construction of homelessness, this brings us back to a central question:

Is it society that decides when there is order or disorder? Is it physicians? It is likely that the apparently innocuous term ‘clinically recognizable symptoms’ in the definitions of mental disorder in *DSM*4 and *ICD*, quoted above, in fact does a lot of work, suggesting that it is physicians, or ‘clinicians’, who are the arbiters of what is normal and what is not. (Bolton 2001, 187)

For again, if I am correct that the reason for the inflation of prevalence rates of mental illness, in particular ASPD, among the homeless is due to the fact that common features of the homeless experience are being medicalized as symptoms of a disorder that is moral and not clinical in nature, then we are faced with several possible conclusions. On the one hand, we certainly do not have to deny, as Charland reminds us, that the types of behaviors picked out by ASPD and other personality types are *empirically valid* behaviors; that is, the behaviors that ASPD picks out really do exist and can be empirically verified. Thus we might conclude that, even though ASPD is a type of personality disorder which fails to capture any valid clinical ‘entity’, it nonetheless captures and describes some elements of behavior which do in fact represent other clinically valid syndromes, such as depression or bipolar disorder. In this case it would be argued that disorders such as ASPD, while perhaps not capturing any determinate clinical ‘entity’, still serves to enhance our understanding of mental disorders more generally, in essence ‘pointing us in the right direction’ in the examination and identification of more clinically based disorders. Under this view, the inflation of prevalence rates of mental illness among the homeless, even when due to the medicalization of potentially morally or socially deviant behavior, is simply an inevitable outcome of the attempt to capture
and describe specific mental disorders in a given population. Here, clinicians are not seen as ‘arbiters’ of what is normal and what is pathological; rather, they are seen as collectors of a wide set of data which inform their clinical practice and which they have at their disposal. Clinicians and therapists then may choose for themselves whether or not to utilize the data sets captured by the categories of mental disorder that are laid out in the ‘neutral, descriptive language of the DSM’, such as ASPD.

The reason this response is not satisfying is three-fold. First of all, as Charland points out, if it is true that personality disorders such as ASPD are not clinically valid syndromes, then a serious concern is raised as to “…whether clinically trained therapists have the requisite skills and knowledge to conduct the sort of moral treatment required to treat Cluster B disorders-moral disorders would appear to require moral treatment and professional clinicians are not normally trained for that.” (Charland 2004, 117) In the case of some treatments for borderline personality disorder, for example, there are clear moral goals that are established between therapist and client whose success of attaining “hinges largely, if not entirely, on the therapist’s ability as a moral being rather than a professional clinician.” (Charland 2004, 124) Thus to claim that the ordinary role of a clinician is merely utilizing at his or her behest the information captured by the categories of mental disorder laid out in the DSM is a bit disingenuous at best. This is especially true when “…nothing in the professional clinician’s training arsenal seems designed to prepare them to be a moral being, which is the starting point of their professional therapeutic relationship with their client.” (124) Secondly, this response is dissatisfying because it seems to assume that therapists and clinicians are completely immune to the moral disorders associated with Cluster B personality types. In other words, it assumes
the clinician or therapist is not susceptible to the same types of behavioral syndromes of the moral disorders they purport to be treating. The objection could be made that the therapist or clinician is just as susceptible to the moral disorders included in Cluster B types, thus making it possible that he or she might not be capable or morally competent to administer his or her duties as a moral agent. And, since there seems to be no way to ensure that the therapist or clinician is in fact morally capable or competent, there is no way of knowing if the patient’s treatment will be properly administered. This seems an especially serious objection to the “observer-objectivity” of clinical psychiatric practice, especially if professional clinicians and therapists are implicitly acting as moral agents without any training or preparation to deal with patients as fundamentally moral agents.

Thirdly, the response that inflated prevalence rates of ASPD among the homeless are to be expected, or at least are not that statistically significant, seems to ignore the criticisms that are associated with the consequences of medicalizing social problems. This point has been illustrated in a wide variety of literature, particularly with regard to the issue of homelessness in the United States. Thus Bogard (2001), commenting on the overall effect of medicalizing homelessness which occurred in the late 1970s and early 1980s, says that

Medicalization of “deviant” populations more generally has been a persuasive typification in the past few decades because it mollifies middle-class moral scruples with its claims to “treat” the “pathologies” of these “victims”- thus allowing for guiltless containment of deviant populations while they are being “helped”. Medicalization both makes the people subjected to it “other” and clearly demarcates boundaries between normative citizens and deviant others.

(Bogard 2001, 448)

This basic criticism is echoed by Lyon-Callo (2000), Mathieu (1993) and others who argue that “as long as homeless people were biomedically represented as deviant, their
living on the streets could be ‘solved’ by housing them in shelters and forcing them into
treatment programs”, thus diverting attention away from systemic social inequities which
contribute to the problem. (Lyon-Calvo 2000, 328) However, as Lyon-Calvo goes on to
argue, there is a yet more serious criticism that can be leveled against the response that
medicalization of moral behavior is an inevitable part of the discovery, examination and
description of other clinically valid syndromes. In his four-year ethnographic
investigation into homeless shelters in Massachusetts, Lyon-Calvo concludes that the
“…routine, everyday practices undertaken by shelter staff and guests to resolve ‘diseases’
actually produce and reinforce dominant imaginings about homelessness and homeless
people, and, thus, contribute to producing particular subjectivities, experiences, self-
images, and behaviors among homeless people.” (328) In this way, he argues, there is a
certain feedback that is created in shelter practice and treatment which ends up producing
or helping to create the very personalities, subjectivities and behaviors the shelter
programs aim to treat in the first place.

If this is true, the response that medicalization of moral behavior is an inevitable
part of the discovery, examination and description of other clinically valid syndromes
seems to be entirely inadequate, for one simple reason: if homeless shelters are in effect
the new mental institutions of today as it is claimed, and such institutions are partly
responsible for creating or producing the very behaviors and personality types they claim
to be treating, then the distinction between medicalization of typical behavior and
genuine mental illness necessarily breaks down. Mental health professionals working in a
clinic for the homeless, for example, would not be able to make a distinction between
symptoms of a clinically valid disorder (depression, bipolar disorder, etc) and
‘symptoms’ of a medicalized moral disorder (Cluster B personality disorders), since the latter could be construed as an indicator, or symptom, of the former. Indeed, this is what appears is occurring in the inflation of prevalence rates of ASPD among the homeless, where normal features of being homeless, what Lyon-Callo calls “coping strategies” of the homeless, are read as symptoms of the disorder itself. Among numerous examples, Lyon-Callo cites the following case:

Ariel, a white women in her late fifties, first came to the shelter in May of 1993. Ariel had maintained a lower-middle-class life, doing light clerical work until the mid-1980s. When she was no longer able to find such work because of her age and computerization, she began to try to support herself through house cleaning. In 1993, she lost her room at a local rooming house when she was no longer able to secure enough work to pay rent….As soon as Ariel entered the shelter, staff members went to work trying to help her. The strategy used was that of uncovering the disorders within Ariel that resulted in her homelessness. As with most of the hundreds of homeless people I have met, Ariel was full of self-blame and, consequently, was quite angry and upset over her situation when we first met. As she put it, "I didn't know what to do with this anger, so I blamed myself," Ariel's feelings of anguish would be manifested in her sometimes losing her patience with a fellow guest, becoming distraught, crying, and feeling unable to concentrate at times. She was clearly in a great deal of emotional pain. A few times, she was forgetful in the kitchen, and tea kettles were left on the stove unattended….Ariel's emotions and behaviors were read by most staff as symptomatic of a mental illness. She was characterized as "clinically depressed” or suffering from post-traumatic stress disorder.

(Lyon-Callo 2001, 340)

Following the diagnosis, shelter staff developed a treatment plan for Ariel which included counseling therapy and anti-depressant medication. According to Lyon-Callo, this and other examples illustrate what he calls the “hegemony of the medicalized discourse of deviancy” (340) which operates within homeless shelters and clinics. Through this medicalized discourse, fairly normal or common features of homeless behavior are read as symptoms of not just mental illness generally, but specific and clinically valid syndromes. In this way, the distinction between clinically valid disorders and medicalized moral disorders begins to break down, since behaviors which are common responses to personal and moral circumstances are read as “symptoms” or tell-tale signs of a clinical
disorder. Thus, the response that the medicalization of moral behavior is an inescapable or foreseeable consequence in the attempt to capture and describe other clinically valid disorders falls short of addressing this clinical-moral breakdown.

In conclusion, I have explored the ways in which a medical-scientific discourse of homelessness has been shaped and influenced by the rise to prominence of the biomedical model of psychiatry of the last twenty years. I have argued that our contemporary understanding of homelessness has been significantly shaped by this biomedical psychiatric discourse, but that it is fundamentally overlain with the myths of observer-objectivity and value-neutrality. I have argued that since ASPD is the most prevalent mental disorder found among homeless populations, and since ASPD and other related personality disorders are arguably moral and not clinical in nature, the disorders most prevalently found among the homeless are ‘moral disorders’ rather than clinically valid syndromes. My argument is further supported by the observation that prevalence rates of ASPD among the homeless are inflated due to an inherent diagnostic bias involved in the medicalization of typical homeless behaviors. This shows, I argue, that there exists both a definite observer-relativity and crucial moral component in the diagnosis, examination and treatment of the ‘homeless mentally ill’.
CHAPTER III

PLATO AND THE ORIGIN OF MENTAL HEALTH

When Foucault spoke of conducting a “genealogy of the modern soul” (Foucault 1984, 176), he referred to and summed up one common theme of his overall research, namely the ways in which the human subject is historically constituted through a rational relationship to itself. For Foucault, ‘the soul’ ought to be seen not as some dated theological artifact, but rather as a necessary reference point or placeholder for the various technologies of the self that have shaped the human subject, and thus our very understanding and conception of the modern self. As Foucault shows, the concept of the soul is inseparable from the Hellenistic understanding of the self; it is inseparable from an understanding of early Christian exegesis; it is inseparable from the modern discourse of criminal psychiatry and punishment; and it is inseparable from our contemporary understanding of the autonomous citizen. In each of these periods, the concept of the soul is a product of a certain type of reasoning, a certain discursive regime that “renders the soul thinkable in terms of a psychology, an intelligence, a personality, and hence enables certain types of action to be linked to certain types of effect.” (Rose

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25 See lectures three and four of January 13th and 14th, 1982 in The Hermeneutics of the Self, pg. 43-80; particularly pg. 53-54. (Foucault 2005)

26 See lecture thirteen of February 17, 1982 in The Hermeneutics of the Self, pg. 247-270; particularly pg. 255-258, (Foucault 2005)

27 Describing the constitution of ‘the little soul of the criminal’ or, “the delinquent”, in the 17th and 18th century (Foucault 1984, 22-223), Foucault quotes one French reformer remarking on the benefits of psychiatric biographical practices: “If long before the crime, long before the charge is laid, you can scrutinize the defendant’s life, penetrate into his heart, find its most hidden corners, lay bare all his thoughts, his entire soul.” (Foucault 1984, endnote p. 225)

28 In his book Governing the Soul, Rose explores and uncovers the ways in which the modern self has been constituted by the management and government of subjectivity in modern societies. “The ‘soul’ of the citizen”, he observes, “has entered directly into political discourse and the practice of government.” (Rose 1994, 2)
In this way, a discursive regime of the soul forms and shapes different subjectivities, profiles, experiences, expectations, boundaries and limits of the ‘self’ which are expressed in and reflective of the particular historical and cultural conditions of which they are a part.

In this section then, I attempt to trace out the conceptual foundation upon which a discourse of the soul might be constructed. I do this by examining the ways in which Plato helps us understand madness, and in turn, providing a discursive foundation for two ways of speaking about the soul. I claim that Plato makes possible two distinct discourses of the soul by which we come to examine the soul, or the self. My argument for this conclusion is based on my reading of the *Timaeus* (86b-87b) with regard to Plato’s distinction between two types of madness. One type of madness provides the foundation for a moral discourse of madness which entails moral determinations concerning pleasure, sexuality, and behavior, and which may or may not include physical or scientific explanations and causes. The other type of madness present in the *Timaeus* provides the foundation for a medical-scientific discourse of madness that is centered around physiological questions concerning pain and ‘harmful dysfunction’, and which does not necessarily entail the logical condition of any moral determination.

My argument for two distinct forms of madness in Plato is two-fold. First, I argue that the identification, diagnosis and etiology of each type of madness is necessarily distinct. In the case of madness due to the excessive suffering of pain, the identification or recognition of such madness would only require an inductive inference from the self-report of a subject who is “unable either to see or hear anything correctly”, and perhaps a
self-report of excessive suffering of pain. In contrast, the madness due to excessive
pleasure of intemperate actions, a full identification or diagnosis necessary entails the
logical condition of a moral determination, namely the behavioral criteria which specify
what is temperate and intemperate, moderate and excessive, ordered and disordered.
Secondly, utilizing the definition of ‘mental disorder’ found in the DSM, only one of the
two types of madness Plato describes fulfills the criteria for qualifying as a mental
disorder. This suggests that Plato did in fact have two distinct forms of madness in mind.

On the one hand, we can speak of madness in a primarily moral way, while still
retaining a medical discourse that focuses on its complex etiology and explanation. And
on the other hand, we can speak about madness in a primarily medical-scientific way,
while retaining a certain moral ambivalence as to the nature and manifestation of
different types of madness itself. Thus I attempt to uncover the foundations of both of
these ways of speaking about madness in the work of Plato. Secondly, I want to show the
ways in which these two discourses overlap and are used by Plato to make each other
intelligible. Thus I argue that statements and claims to ethical knowledge in Plato are
made comprehensible through a very particular style of reasoning Plato adopts. By using
health and disease as paradigms in the literal sense, Plato is able to make statements
pertaining to the soul intelligible by reference to the example of the diseased body. This
epistemological move of Plato’s creates a “pathology of vice”29 which makes it possible
to speak about the soul in a medical-scientific discourse.

29 Plato’s “pathology of vice” has been commented on directly by Gosling (1973, 84), Mackenzie (1983,
175-178), Lloyd (2003, 146-157; 207-212), and Peponi (2002). Peponi shows how Plato’s medical
discourse in the Philebus creates what she calls a “pathology of love” and of the orgasm itself: “one has to
stay even more faithfully close to medical discourse in order to appreciate what seems to be explicitly
articulated in medicine but intentionally passed over in silence in Socrates’ philosophical analysis: namely,
In the *Timaeus* and the *Laws* Plato advances the mere analogical or metaphorical relationship between the two domains of health and virtue to a literal one, assimilating health to virtue and vice to disease. In this way, Plato advances the dialectic between virtue and health to a strict medical-moral relationship that finally reduces virtue and vice to a matter of pathology. The important result of this move is that it makes possible objective statements about the state of one’s soul; it is a style of reasoning that makes possible an entire pathology of the soul that is presumably subject to the processes of observation, diagnosis and cure. Yet even in the *Timaeus*, where all pathologies of the soul have a physical basis and cause, Plato leaves room for one type of madness that is ambiguous with respect to virtue or vice. This shows us that, even when the two seemingly conflicting views concerning the ‘healing of the soul’ overlap the most – for example in Plato where the virtuous, immaterial soul overlaps with its physical and medical characterization- there is still room left for a concept of madness which remains morally ambivalent.

At *Republic* III 403c, Socrates and Glaucon, completing their “account of education in music and poetry” which ends in “the love of the fine and beautiful”, turn their attention to the physical training that must be prescribed in the ideal city. At III 403d, Socrates and Glaucon agree that “a fit body doesn’t by its own virtue make the soul good, but instead that the opposite is true- a good soul by its own virtue makes the body as good as possible” [403d]. They then go on to “indicate only the general patterns to be

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the apparently established medical analogy between the physical processes of *knesmos* and human orgasm. (Peponi 2002, 156)

30 If not indicated otherwise, citations from *The Republic* are from Cohen, Curd and Reeve (2000), translation by G.M.A. Grube.
followed" in the “detailed supervision of the body” by the guidance of the mind. [403e] The “general patterns” Socrates and Glaucon establish encompass everything from prohibitions on drunkenness [403e], training for wartime [404b], and strict dietary rules including prohibitions against “Syracusan cuisine”, “Sicilian-style dishes” and (my favorite) “the reputed delights of Attic pastries” [404d]. Such a regimen, it is said, “makes for bodily health” just as “simplicity in music and poetry makes for moderation in the soul.” [404e]

Yet such a strict regimen of the body does not, it is agreed, guarantee the health of the soul. Rather it is the health of the soul that guarantees that the body is healthy, “as good as possible”. [403d] Thus the question remains as to how Socrates and Glaucon account for the health of the soul, and what exactly this means. At the end of their account of education in music and poetry, we are given a hint. At 402e, we find out that excessive pleasure and excessive pain are incompatible with moderation and all the rest of the virtues. Furthermore, excess of pleasure, the prime example being sexual pleasure, “drives one mad just as much as pain does” [402e]. Conversely, such excessive pleasures or pains are compatible with “violence and licentiousness.” [403d] Thus the proper and moderate kind of pleasure “has nothing mad or licentious about it”. [403a] Therefore the healthy soul, it appears, will avoid excessive pleasures (i.e. sexual intemperance) and pains (bodily pain or disease) which cause madness and licentiousness.

The interesting result of this is that both excessive pleasures (i.e. sexual intemperance) and excessive pains (bodily pain or disease) are said to be the cause of madness and licentiousness. But why would Plato have us think this? Why is the cause of madness not restricted to excessive pains, and licentiousness by excessive pleasures? In
other words, when it comes to the pathologies of the soul, why does Plato give equal
causal status to both bodily pain or disease and excess of pleasures? I think that the
reason Plato does this is similar to the reason he has for making the distinction in the
Timaeus between two types of madness: one which has direct reference to a moral
discourse (e.g. excessive pleasure), and another which has reference to a medical
discourse but is morally ambivalent (e.g. excessive pain). These two types of madness in
Plato, in turn, provide the basis for a moral discourse of the soul, and another which
provides the basis for a medical-scientific discourse of the soul.

This distinction between two types of madness is made at Timaeus 86b, where
Plato ends his discussion of the diseases of the body to begin a discussion of the diseases
of the soul ‘which are due to the condition of the body’. Plato speaks of diseases of the
soul as arising from the ‘evil conditions of the body’ [86e]. These ‘evil conditions of the
body’ can be explained by “two quite involuntary causes” [87b]. According to Timaeus,

(We) must agree that folly is a disease of the soul; and of folly there are two kinds, the one of
which is madness, the other ignorance. Whatever affection a man suffers from, if it involves either
of these conditions it must be termed ‘disease’; and we must maintain that pleasures and pains in
excess are the greatest of the soul’s diseases. For when a man is overjoyed or contrariwise
suffering excessively from pain, being in haste to seize on the one hand and avoid the other
beyond measure, he in unable either to see or hear anything correctly, and he is at such a time
distraught and wholly incapable of exercising reason. And whenever a man’s seed grows to
abundant volume in his marrow, as it were a tree that is overladen beyond measure with fruit, he
brings on himself time after time many pangs and many pleasures owing to his desires and the
issue thereof, and comes to be in a state of madness for the most part of his life because of those
greatest of pleasures and pains, and keeps his soul diseased and senseless by reason of the action
of the body.” [Timaeus 86b-d]

In this account, ‘folly’ is a disease of the soul that is composed of two kinds: madness
and ignorance. Both madness and ignorance are caused either by excessive pain or
excessive pleasures. On the one hand, madness can be caused by excessive joy or
excessive pain which results in impaired hearing and vision, which leaves one ‘distraught
and wholly incapable of exercising reason’. Here the onset of madness due to excessive pain is explained in terms of physical bodily causes where “in respect of pains likewise the soul acquires much evil because of the body [86e]. This type of madness is thus involuntary, owing to the bodily humours which “penetrate to the three regions of the Soul, according to the region which they severally attack” [87a].

Plato distinguishes this type of madness, I argue, from another type of madness which is caused by the excessive pleasures of intemperate actions. This type of madness is brought about through one’s ‘desires and the issue thereof’. It is the “sexual incontinence” expressed by “the action of the body” [86d] which is primarily responsible for the onset of this madness. Furthermore, the mad subject of sexual incontinence “is reputed to be voluntarily wicked and not diseased; although, in truth, this sexual incontinence, which is due for the most part to the abundance and fluidity of one substance because of the porosity of the bones, constitutes a disease of the soul.” [86d] Therefore this type of madness that is due to excessive pleasure is caused by the intemperate behavior of one’s actions. However, this type of madness, we are told, also comes about involuntarily:

(A)nd indeed almost all those affections which are called by way of reproach ‘incontinence in pleasure’, as though the wicked acted voluntarily, are wrongly reproached; for no one is voluntarily wicked, but the wicked man becomes wicked by reason of some evil condition of the body and unskilled nurture, and these are experiences which are hateful to everyone and involuntary.” [Timaeus 87d-e]

This latter kind of madness is also explained in terms of physical bodily causes, and we are told that “we must always blame the begetters more the begotten” [87b]. However, this does not preclude Plato from making the proviso that “each man must endeavor, as best he can, by means of nurture and by his pursuits and studies to flee the evil and to pursue to good.” [87b]
Thus for Plato diseases of the soul can be explained by reference to the ‘evil conditions of the body’. These ‘evil conditions of the body’ are brought on by “two quite involuntary causes”. On the one hand, there is a type of madness that is caused by excessive suffering of pain, and which is brought about through the wandering of bodily humours. And, on the other hand, there is the type of madness that is caused by the intemperate nature of one’s actions, and which is also brought about through physical causes. These two involuntary causes of madness therefore are 1) excessive suffering of pain, and 2) excessive pleasure of intemperate actions, both of which are involuntary on the basis that each is said to be the result of some humoral disturbance in the body. Plato makes the distinction between these two causes of madness, I argue, because he wants to retain the distinction that he has already made in the Republic between two distinct types of madness. Again, in the Republic, Plato says that excess of pleasure, the prime example being sexual pleasure, “drives one mad just as much as pain does” [402e]. Thus excessive pleasure and excessive pain are said to be the causes of madness. The healthy soul, therefore, will avoid excesses of pleasure and pain.

The reason why these two causes of madness each constitute or bring about two distinct types of madness can be explained as follows. Because of the way in which Plato describes and defines the two causal pathways of madness – excessive pain and excessive pleasure of intemperate action – both the etiology and identification of madness in each case is necessarily distinct. In the case of madness due to the excessive suffering of pain, the identification or recognition of such madness would only require an inductive inference from the self-report of a subject who is “unable either to see or hear anything correctly”, and perhaps a self-report of excessive suffering of pain. From these empirical
facts, which can be easily drawn from a brief medical questionnaire or clinical examination, this type of madness can be inferred or diagnosed. In contrast, the identification of madness which is due to excessive pleasures of intemperate actions logically requires a normative or moral component. In order to be able to identify or diagnose this type of madness, a judgment must be made as to what counts as temperate or intemperate, moderate or excessive, and more importantly, which behaviors or actions are susceptible or open to such moral evaluation. In other words, a subject’s self-report of impaired hearing or vision coupled with excessive suffering of pain would, in this case, not fulfill the criteria to justify the identification or diagnosis of this latter type of madness. A full identification or diagnosis of this latter type of madness necessary entails the logical condition of a moral determination, namely the behavioral criteria which specify what is temperate and intemperate, moderate and excessive, ordered and disordered.

There is another important argument that can be advanced in making the distinction between two forms of madness in Plato. This argument draws upon the current working definition of mental disorder found in the most recent version of the DSM that lays out some general criteria for what counts as ‘disordered’ and what not. According to the definition of ‘mental disorder’ found in the DSM, the argument goes, we can make a distinction between the two types of madness in Plato on the basis of what is called “functional impairment”. The notion of mental disorder as ‘functional impairment’ is what is essentially operative in the DSM-III and DSM-IV. Boysen (2007) rehearses the often-cited definition of mental disorder in the DSM as a

Clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly
increased risk of suffering death, pain, disability, or an important loss of freedom (APA, 2000, p. xxxi) [Boysen 2007, 158]

Here, the criteria for qualifying as a mental disorder includes ‘present distress’ such as pain, or disability due to the impairment of some ‘important area of functioning’. The notion of ‘functional impairment’ has been expanded upon by Wakefield (1992) as “harmful dysfunction”, which is roughly defined as any harm, discomfort or deprivation that is brought on through a failure or breakdown of a function of some mental mechanism. Using these criteria, we can compare the two causal pathways of madness Plato describes in order to see if either fulfills these criteria for qualifying as a mental disorder. The first causal pathway of madness, Plato tells us, is due to ‘excessive pain’. Under this sort of excessive pain, furthermore, one is “…unable either to see or hear anything correctly, and he is at such a time distraught and wholly incapable of exercising reason.” [Timaeus 86b-c] In this description of this form of madness then, we have both the ‘present distress’ of pain and disability due to functional impairment (e.g. failure to hear or see correctly). Furthermore, we can classify this form of madness as resulting from “harmful dysfunction”, since the harm is brought on, or caused by, the excessive pain itself. Thus, we can conclude that this form of madness due to excessive pain fulfills the criteria for mental disorder laid out in the DSM.

However, in the form of madness that is due to the excessive pleasure of intemperate actions it is not apparent that we have either ‘present distress’ such as pain or discomfort, or disability due to any functional impairment. Again, all that is specified is that this type of madness is brought about through one’s ‘desires and the issue thereof’ - namely the “sexual incontinence” expressed by “the action of the body” [86d]. And even though we are told in the Republic that this excessive pleasure “drives one mad just as
much as pain does” (402e), and in the Timaeus that this renders the soul ‘diseased and senseless’, it is still not clear that there is significant ‘present distress’ or even ‘harmful dysfunction’. One might respond that the soul being rendered ‘senseless’ would qualify as a ‘harmful dysfunction’ or at least as a ‘functional impairment’. But this response fails to specify both the nature of the harm, if any, caused by such impairment as well as what it means for the soul to be functionally impaired in the first place. Thus we can conclude that the form of madness due to excessive pleasure of intemperate actions does not fulfill the criteria for mental disorder found in the DSM.

Therefore, we can say one of two things with regard to the two forms of madness in Plato. On the one hand, we can say that there are two forms of madness that Plato distinguishes, but that only one of which should be considered as a genuine ‘mental disorder’. This position would argue that the madness due to excessive pain, which causes harmful dysfunction, fulfills the criteria for qualifying as a mental disorder in the DSM definitions, but that the madness due to excessive pleasure does not, and therefore should not be considered a mental disorder. In other words, we would end up saying that the madness due to excessive pain would be “clinically recognizable” as a mental disorder, but that the latter form of madness would not. On the other hand, we could say that the two forms of madness Plato describes each capture different elements of what we want to call ‘mental disorder’, and that these elements are captured by speaking about mental disorder in different ways. This reply would suggest that the DSM definition of ‘mental disorder’ is too narrow, and that both forms of madness Plato presents ought to be considered as just different ways of describing mental illness and the symptoms that accompany it.
There are good reasons to reject the latter interpretation. That is, there are good reasons to think that Plato really is describing two distinct forms of *madness*, and that one ought to be considered ‘clinically recognizable’ as mental illness and the other not. First, as I have argued, both the identification or diagnosis as well as the etiology of the two forms of madness are necessarily different. In addition, we need to be reminded that the medical-scientific discourse of madness as ‘mental illness’ is a product of the nineteenth century, and that Plato simply did not have such a notion in his understanding. Our contemporary understanding of ‘mental illness’ is necessarily conditioned by the scientific appropriation of madness which Foucault describes in such detail (Foucault 2006; 1984). Boysen echoes this point by saying that “the conceptualization of mental illness as biological is as old as mental illness itself”, noting the transformation that psychiatry went through during this period in which the prominent view arose that, for example in 1867, “…‘patients with so-called mental illnesses are really individuals with illnesses of the nerves and brain. (as quoted in Bentall, 2003, p. 150)” [Boysen 2007, 164] Thus it is incorrect to say that Plato is simply speaking about *mental illness* or *mental disorder* in two different ways. ‘Mental illness’ or ‘mental disorder’ refer only to one particular discourse – a medical-scientific discourse – of madness which is a product of the nineteenth century. My argument is that Plato gives us two distinct ways of speaking about *madness*. On the one hand, we can speak of madness in a primarily moral way, while still retaining a medical discourse that focuses on its complex etiology and explanation. And on the other hand, we can speak about madness in a primarily medical-scientific way, while retaining a certain moral ambivalence as to the nature and manifestation of different types of madness.
The relationship between the moral and the ethical domain in Plato is admittedly complicated – if they can even be neatly separated out in ‘domains’ at all. It is clear, however, that ethical knowledge for Plato is based upon the complementary concepts of disease and pathology (πάθος), where

(G)oodness or virtue or excellence in every important domain turns out to be a matter of good order between potentially hostile elements (cf. Timaeus 87c4) [T 6.15]. Any disorder must be remedied by cures, purges, purifications, to restore, as far as possible, the original ideal balance.”

(Lloyd 2003, 157)

This allows a truly paradigmatic case of disease and pathology, where the diseased soul, riddled with the hostile elements (πάθος) “…will run to the judge, as he would to the physician, in order that the disease of injustice may not be rendered chronic and become the incurable cancer of the soul”. (Plato 1878, 69) However in the passage just cited from the Gorgias, the relationship between disease and vice is much weaker than it appears in the Timaeus and the Laws. In the Gorgias, this type of medical reasoning appears as a paradigm in the strictly epistemological sense – as a didactic example to help us better understand virtue and vice. But by the time we get to the Timaeus and the Laws, the relationship between pathology and health has advanced much further. On this account, vice becomes truly a matter of pathology, such that “(D)iseases of the soul occur through the disorder of the body.” (Mackenzie 1981, 176) This includes a broad range of πάθος including “overflowing bone marrow” causing madness (176), physical disturbances causing “sexual intemperance” (177), and general disorders of the body which lead to “excessive sensation of pleasure and pain”. (176) As Mackenzie points out, such a “pathology of vice” is subject to the same “…difficulties and limitations that beset any scientific discipline, but nevertheless capable of analysis from observation and
experiment” such that vice can be diagnosed, explained and cured. (177) One further implication of this is that “the legislator should no longer be analogous to, but identical with, the doctor.” (177) Thus Plato, in the *Timaeus* and *Laws*, advances the relationship between pathology and health from a paradigm, or didactic example, to a relationship of causal dependence. In other words, whereas in the *Gorgias* and parts of the *Republic* where the virtue is said to be a form of health or well-being, the *Timaeus* and *Laws* has virtue and vice assimilated to health and disease in the literal sense.

However, as Lloyd remarks, the various senses of the word πάθος in Greek culture allowed for much more conceptual room than its strictly medical interpretation. *Pathe* were considered entities which imbued some effect, and could refer to anything that happened to you or that you underwent or suffered. “*Pathe*” Lloyd says, “were not necessarily negative items, ailments that had to be removed. The word is often translated ‘affection’ or ‘feeling’ and in Greek psychological theories it is often interpreted by modern scholars as denoting especially what we call the emotions.” (Lloyd 2003, 11)

Thus even in the *Timaeus*, where all pathologies of the soul have a physical basis and cause (*pathe*), Plato leaves room for a type of madness that is ambiguous with respect to virtue or vice. Even the *pathe* which is said to be responsible for the disturbance of congenial health can refer to an entire range of human emotion, feeling and behavior. This shows us that, even when the two seemingly conflicting views concerning the ‘healing of the soul’ overlap the most – for example in Plato where the moral and immaterial soul is assimilated to a physical and medical characterization- there is still room left for a concept of madness which remains morally ambivalent.
Thus by making the ethical domain of knowledge more intelligible by using the paradigm of health and disease, and by adopting a pathological style of reasoning that is embedded in that medical paradigm, Plato is able to make statements and claims about the soul comprehensible. In this way, Plato makes possible a truly medical-scientific discourse of madness and the soul. Through the logic inherent to Plato’s pathology of vice, we are able to comprehend statements and claims about the soul as being true or false. Yet again, this comprehensibility comes about not merely through analogical or metaphorical assertion, but through a specific style of reasoning which reduces virtue and vice to health and disease by reference to pathology. However, even in Plato’s pathology of vice, there is still room left for a type of madness which is morally ambivalent. Indeed, even what is considered the pathological basis of this madness is allowed a moral ambivalence which can refer to an entire range of emotions, feelings and behaviors.

Thus, we have seen that there are two distinct forms of madness in Plato. First, I argued that the identification, diagnosis and etiology of each type of madness is necessarily distinct. In the case of madness due to the excessive suffering of pain, the identification or recognition of such madness would only require an inductive inference from the self-report of a subject who is “unable either to see or hear anything correctly”, and perhaps a self-report of excessive suffering of pain. In contrast, the madness due to excessive pleasure of intemperate actions, a full identification or diagnosis necessary entails the logical condition of a moral determination, namely the behavioral criteria which specify what is temperate and intemperate, moderate and excessive, ordered and disordered. Secondly, utilizing the definition of ‘mental disorder’ found in the DSM, only one of the two types of madness Plato describes fulfills the criteria for qualifying as a
mental disorder. This suggests that Plato did in fact have two distinct forms of madness in mind – one which has direct reference to a moral discourse, and one with direct reference to a medical-scientific discourse.

And, as I showed in Section I, a medical-scientific discourse of madness and the soul is taken up in the Enlightenment and expanded upon in the attempt to create a truly objective and value-neutral conception of mental illness and mental disorder. Furthermore, we have seen a re-formation this medical-scientific discourse in the form of the biomedical model of psychiatry of the last two decades which has in turn significantly shaped our contemporary understanding of homelessness in the United States. Thus the influence of Plato in providing the foundation for this medical-scientific discourse should not be understated, for how we understand the practice of psychiatry or, the ‘healing of the soul’, would not be possible were it not for the way in which Plato provided us a new way to speak about the soul in a semi-moral/semi-medical way.

However, unlike the distinction we get in Plato between two distinct forms of madness, the nineteenth-century discourse of mental illness- and its re-formation in the biomedical model of psychiatry- treats madness as primarily an object of medical science (mental illness or disorder), imposing upon it the myths of objectivity and neutrality.

Even though Plato helps us understand statements about the soul by making them more intelligible though the paradigm of health and disease, Plato – unlike the biomedical discourse of psychiatry- does not pretend that the topic of madness is entirely exhausted by a medical-scientific discourse. Rather, on the one hand, we can speak of madness in a primarily moral way, while still retaining a medical discourse that focuses on its complex etiology and explanation. And on the other hand, we can speak about madness in a
primarily medical-scientific way, while retaining a certain moral ambivalence as to the nature and manifestation of different types of madness itself. I believe that we find in Plato the foundation for both of these ways of speaking about madness, which together can potentially give us a positive and promising framework in which to deal with madness in contemporary times.
"Too often, homeless mentally ill people are treated as simply a collection of symptoms and problems."\textsuperscript{31} This statement is true in many ways that are reflected directly in my thesis. It is true historically, through the discursive formation of homelessness and the rise of the biomedical model of psychiatry of the last two decades. It is true in practice, seen in the inflation of prevalence rates of mental illness due in part to the medicalization of homeless behaviors. And it is true in public perceptions and attitudes towards the homeless in general, as authors such as Arnold, Mathieu, Allen and others have noted. The aim of my thesis, then, is to provide a critique to and challenge of this dominant discourse of homelessness. Specifically, I wanted to challenge the legitimacy of some of the most prevalent diagnostic labels that are found among homeless populations, and secondly to question the adequacy of that same medical-diagnostic framework.

Most of the research for my thesis is inspired by both my interest in the issue of homelessness and Foucault’s early and middle works and lectures on madness and mental illness, psychiatry, and abnormality. In particular, I am interested in the ways that issues such as homelessness are problematized in their historical and cultural contexts. This

methodological approach partially describes Foucault’s own genealogical method, which provides a lens of both keen understanding and critique. Indeed, the critical power of Foucault’s method lies in its ability to uncover the apparent inevitability, the seemingly immutable way that we view the world and the concepts that we use to represent it. Genealogy, and its approach as problematization, allows us to see the historical contingency of our perceptions, concepts and ways of viewing the world – the counterfactual nature of our most common epistemological lenses. In the case of homelessness and mental illness, it allows us to see that there is a discursive struggle which exists between different lenses of viewing, and knowing, homelessness. Problematizing the issue of homelessness as a site of discursive struggle enables us, furthermore, to trace out the ways in which these different lenses of knowing have been constructed along sites of power-knowledge. In this way, Foucault’s method provides the framework for my research into the different ‘lenses’ of knowing the homeless mentally ill, and the ways in which these lenses are constituted in their historical and cultural contexts.

However sometimes genuine critique falls well short of constructive philosophical dialogue – a positive problematization, if you will. Critique which ends at mere criticism or extravagant deconstruction, it is charged, is not helpful in philosophically advancing a dialogue – one must provide a possible way forward, a plausible answer to the problem at hand. This criticism is a common one that is often laid at the feet of Foucault’s critical approach, albeit often with undue haste and an uncharitable reading of Foucault’s life’s work. Indeed, it is a significant failure not to recognize that since one of Foucault’s major themes involves, for example, describing and excavating the historical formation of the
self, his later works that deal explicitly with the ‘care of the self’ as a possible foundation for a contemporary ethics can be seen as Foucault’s initial attempt at providing that constructive, positive way forward. In fact, Foucault himself spoke of his later work on the ‘care of the self’ as an attempt to begin new research in ethics, and building up a new problematization of the self which would avoid as far as possible those elements of disciplinary power which he critically exposed in his mid-to-late works. Thus a genealogy should be seen as perhaps the critical aspect of an inquiry which makes possible a constructive and positive problematization based upon the knowledge gained from that genealogical critique.

Investigating the discursive formation of homelessness in the United States, then, is a part of that genealogical critique which allows us to step back and examine the different lenses through which we have come to understand the homeless mentally ill. However this critical aspect, if it is to be constructive, calls for a positive problematization of the issue which provides the dialogue a way forward. Towards this end, I briefly point to a collection of several movements, organizations, and outreach programs that have already taken on this task of altering the lens through which we view homelessness and mental health, and providing practical solutions and services directly for homeless individuals who have been diagnosed with serious mental illnesses. These organizations and outreach programs are on their own relatively small, but together they represent a broad coalition of groups and individuals who are trying to build up a framework of homeless care and advocacy that focuses on both 1) harm reduction, community, compassion, provision of basic needs, and free or low-cost medical and mental health services, and 2) destigmatization, racism, sexism, and other forms of
discrimination which are manifested in mental illness. These two foci provide a framework of homeless care and advocacy which provides a new lens through which to view homelessness and mental health, and perhaps madness in general.

Caduceus Outreach Services is a non-profit organization founded in 1996 based in San Francisco that provides mental health services including “…psychiatric treatment, intensive case management, social services, community support and advocacy in a harm reduction framework.”32 However Caduceus is much more than a psychiatric treatment center. Caduceus is funded through foundation grants, federal homelessness programs, and private donations, allowing all services to provided free of charge. In addition, Caduceus psychiatrists volunteer their time to provide case management and what they refer to as “restorative treatment”. On a practical basis, clients are provided with “…intensive social support, therapy, medications, drop-in crisis services and psychiatric clinics, criminal court and probation advocacy, and ensuring that our clients obtain disability benefits, health insurance, and housing.” (ibid) In any given year, Caduceus provides over 100 clients donated psychiatric services which come to a total of over $100,000. Clients interact with psychiatrists, social workers and one another on a come and go basis, in a “non-clinical” setting where they may prepare food for themselves, use the phone and computer, play chess, sleep, create art, hang out, or see a counselor or psychiatrist in a private office (ibid).

On a theoretical level, Caduceus adopts what they call a harm reduction strategy within a social justice mindset. This means that emphasis is placed on two foci, one being the ‘harm reduction’ strategy in promoting mental health and the other being social

32 Caduceus Newsletter, Caduceus Outreach Services: The First Ten Years. 2006
http://www.caduceusoutreachservices.org/Caduceus_newsletter.pdf
justice. “(F)rom our inception”, they state, “…we have recognized and acknowledged people’s intelligence, skills, creativity, and resilience, as well as their illness, poverty, trauma and pain.” (ibid) In this way, Caduceus workers are competent and responsive to both acute mental illness as well as social, moral and personal needs. The non-clinical setting is an attempt to shed from psychiatric practice the often ambiguous character of clinical practice, as well as the ‘objective medical gaze’ of psychiatry. Indeed, Caduceus states that “(P)erhaps most importantly, our clients can find respite from the fear and exhaustion of the streets in the safe company of others who will not fear, reject, judge or stigmatize them for being homeless or, mentally ill.” (ibid) In this way, Caduceus becomes a “sanctuary of safety and healing” which breaks away from the ‘myths of objectivity and neutrality’ that mark the mainstream biomedical model of mental illness. Although the clinician-client relationship still exists to some extent which “…makes each individual a ‘case’ ” (Foucault 1984, 203), such a setting drastically reduces the effect of the medical gaze of objectivity and neutrality which exists in a traditional clinical setting.

Creating such a space for open, welcoming and compassionate care is absolutely crucial for those diagnosed with mental illness, especially the homeless. Research has demonstrated overwhelmingly that the effects of ‘mental illness stigma’ are much more pronounced than previously thought. Mental illness stigma refers to the stigmatizing effects of the way in which society at large deals with and treats those diagnosed with mental illness. As one researcher on mental illness stigma puts it, “(S)tigma is evident in the way laws, social services, and the justice system are structured as well as ways in which resources are allocated. Research that focuses on the social structures that maintain stigma and strategies for changing them is sorely needed.” (Corrigan and Watson 2002,
Mental illness stigma, like many forms of stigmatization, has become a hot topic among psychologists, sociologists, and mental health professionals alike: “Indeed, more than 40 negative consequences of stigma have been identified, including discrimination in housing, education and employment and increased feelings of hopelessness” (Hocking 2003, S47). On top of the strictly social stigma that plagues mental illness, what is called “self-stigma” and “self-discrimination” are said to have all sorts of deleterious effects on those with mental illness as well. Self-stigma refers to the internalization of prejudice that those diagnosed with mental illness inherit, while self-discrimination refers to the discriminatory effects of such internalization. Indeed, “(R)esearch suggests self-stigma and fear of rejection by others lead many persons to not pursuing life opportunities for themselves” (Corrigan and Watson 2002, 18), as well as invoking a sense of hopelessness, anger and outrage. This stigmatization process and all its implications for those with diagnosed with mental illness are so great that many in the mental health profession are recognizing that “(I)t is important, therefore, for clinicians and other healthcare workers to appreciate that stigma and its associated prejudice form a very real barrier to recovery and may even be fatal.” (Hocking 2003, S47) Caduceus is certainly a place where these dangers and barriers to treatment are recognized up front, and as a result transformed itself into a space of inclusion, community, openness and hope.

The National Alliance for Mental Illness (NAMI), established in 1979, is an education, awareness and advocacy organization that works “…at all levels to ensure that all persons affected by mental illness receive the services that they need and deserve, in a timely fashion”, based on the firm belief that “(M)ental illnesses should not be an
obstacle to a full and meaningful life for persons who live with them.” Based on the concepts of recovery, resiliency, and support, NAMI provides public education campaigns, peer support groups, de-stigma campaigns and state and federal advocacy for changing the way mental illness is viewed and how those struggling with mental illness are served and supported. However, at least since 1999, NAMI has been embroiled in several controversies, in particular the most recent congressional probe into its financial connections with the major pharmaceutical companies such as Eli Lilly and GlaxoSmithKline. Indeed, within the last year or so, the media coverage on the pharmaceutical industry’s influence on domestic drug policy has increased dramatically, prompting many within the mental health establishment and elsewhere to address the question of conflicting interests of those who claim to be providing objective answers to those diagnosed with mental illness.

Like most categories of stigmatization, there has been a significant effort on the part of some mental health groups to not just de-stigmatize mental illness, but to assert their voice as an active and engaged part of society. The ‘Mad Pride’ movement, as it is called, began around 1999 as a movement to ‘reclaim’ terms that have traditionally been used to (usually) pejoratively refer to those with mental illness –‘batty’, ‘nut-job’, or just plain ‘crazy’ or ‘mad’– in the attempt to assert the voice of ‘mad culture’ and those diagnosed with mental illness who have been marginalized and silenced. As a nicely written and recent piece in the New York Times put it, “(J)ust as gay-rights activists reclaimed the word queer as a badge of honor rather than a slur, these advocates proudly

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call themselves mad; they say their conditions do not preclude them from productive lives.”

The ‘Mad Pride’ movement covers a quite diverse and broad range of groups, ranging from those working for destigmatization within the mainstream mental health system, those who advocate and provide alternative mental health services such as yoga, exercise and spiritual healing, and those who outright reject biomedical solutions to mental illness altogether. Regardless of the diverse orientations towards medical-pharmacological solutions to mental illness, these groups do have one primary thing in common: “(T)hey seek to celebrate aspects of a culture of having had some mental health problems. And, in so doing, they try to attack some of the prejudice. Most importantly, they do it with humour.”

Other organizations associated with the Mad Pride movement include groups such as the Icarus project, a peer-to-peer mental health network and support group based out of New York with chapters established worldwide, and MindFreedom International, an independent non-profit organization that works for mental health alternatives and human rights. Most of these groups endorse what they call a “pro-choice harm reduction” strategy in which people are empowered to make their own decisions whether they want to take prescribed medications or not, and they make clear that all treatment decisions ought to be made with true informed consent and full openness about the risks involved. This basic approach, combined with the emphasis on social justice, creates a powerful strategy for addressing the overall needs of those diagnosed with mental illness. Caduceus does just this by adopting a harm reduction strategy within a social justice framework, providing services to those in need without the stigmatizing effects of a

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clinical psychiatric evaluation; or in other words, without the silencing effects of the clinical medical gaze.

My experience with Robert allowed me to recognize two important things. First of all, I learned how easy it is to view homelessness through the dominant lens of the medical gaze. How easy it was to explain Robert’s behavior and place him into a neat category of ‘otherness’ by simply adopting the dominant medical lens which views mental illness as a debilitating, impairing and perhaps even shameful condition. The idea that his behavior was in fact perfectly rational and necessary to his well-being was, because of the lens of the medical gaze, not even on my radar. Secondly, I learned just how proximate and tangible madness is to each and every one of us. I say “madness” because, as I hope my thesis suggests, ‘mental illness’ is a primarily technical and/or scientific term which has dominated the discourse of madness only fairly recently. In addition, ‘mental illness’ has historically been associated with ‘abnormality’, a term that all too often has proved controversial and/or unscientific. Madness, on the other hand, is a term for which we have a long historical discourse. It is manifest in many different ways across different eras and places; it is expressed, experienced, and interacted with differently across cultures and within local communities; and yet again, it is “both frighteningly, palpably present, and yet elusive.” (Luhrmann 2000, 10)

For this reason, both a moral and a medical-scientific discourse of madness are important in talking about madness. However, there needs to be an open and honest discussion of why the semi-technical, semi-scientific concept of ‘mental illness’ or ‘mental disorder’ is an improvement over - or at least any better than – a more nuanced concept of madness. In other words, what is gained by a quasi-scientific knowledge about
‘mental illness’ or ‘mental disorders’ that we wouldn’t get from a broader notion of madness? There are good reasons to jettison the concept of ‘mental illness’ or mental disorder in favor of a much broader and expanded conceptual field in which to discuss madness as both a moral/social/cultural phenomenon, as well as a biological-medical one. First, since there are no medical tests for any specific pathology for any major psychiatric illness, and since there is no good reason to believe that this will change any time soon (Luhrmann 2000, 20), the technical term ‘mental illness’ and more specifically ‘mental disorder’ just lacks any determinate referent that we can speak of. And to lead one to believe that ‘mental illnesses’ can be reduced to biological phenomena is wholly ingenuous, as there is no identifiable biological component to any major psychiatric disorder (Boysen 2007, 159).

But perhaps more importantly, we might consider jettisoning the term ‘mental illness’ as a technical label merely on the basis of the stigmatizing and essentializing effects such diagnostic labels have on those diagnosed. And while it might be argued that people cannot receive medication without a proper valid diagnosis from a licensed practitioner, it is not at all clear that the benefits of pharmacological treatments for mental disorders outweigh the costs that are associated with the experience of being diagnosed, labeled and stigmatized as such. Thus if the benefits of maintaining the technical diagnostic framework of mental illness do not clearly outweigh the costs, then a serious conversation ought to be going on about the legitimacy, efficacy and I would argue morality of that framework. Perhaps a good place to start is being honest about the nature of psychiatry and issues about mental health that seem to be masked by the biomedical model of diagnostic categories and labels. In this way, we might begin – or rather
continue – a dialogue about *madness* which can be accessed through both a moral/social/cultural lens as well as through a medical/biological lens. This is something I do not think is possible with ‘mental illness’, particularly when it refers to the diagnostic categories and labels contained and described in the DSM system. And although the biomedical model of ‘mental illness’ might be helpful and insightful into the various aspects and manifestations of what we might call *madness*, it admittedly has fallen well short of addressing the long and complex history that has given rise to the very notion of ‘mental illness’ in the first place.

Indeed, as Foucault says, since the constitution of madness as mental illness in the eighteenth century, there has been a fundamental “rupture in the dialogue” between the madman and the man of reason. (Foucault 2006, xxviii) The language of mainstream psychiatry and the DSM sees madness as an object of a medical gaze – a scientific “…monologue by reason *about* madness” (xxviii). This is why a new dialogue demands to be built up in which madness is no longer framed exclusively within scientific categories and diagnostic labels. Organizations like Caduceus, NAMI, the Icarus Project, Mad Pride and others are part of that new dialogue which is helping to form a new way of viewing and knowing mental illness. This dialogue contributes to the positive problematization of madness that stands as a promising way forward for both those working in mental health as well as those who are diagnosed with mental illness. Perhaps posing the contemporary problem of *madness* and non-madness in this way

“…can open, in a language more original, much rougher and much more matutinal than that of science, the dialogue of their rupture, which proves, in a fleeting fashion, that (madness and reason) are still on speaking terms. There, madness and non-madness, reason and unreason are confusedly implicated in each other, inseparable as they do not yet exist, and existing for each other, in relation to each other, in the exchange that separates them.” (Foucault 2006, xxvii)
REFERENCES


## APPENDIX

### FIGURE 1

### Table 3

**Lifetime Prevalence of DSM-III Mental Illness in Homeless Populations Compared With the Combined Five-City NIH ECA Household Survey Population**

<table>
<thead>
<tr>
<th>Case finding method/Study</th>
<th>n</th>
<th>Male (%)</th>
<th>Schizophrenia</th>
<th>Affective disorder</th>
<th>Dementia</th>
<th>Antisocial personality</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bassuk, Rubin, &amp; Lauriet, 1984</td>
<td>76</td>
<td>83.0</td>
<td>30.3</td>
<td>9.2</td>
<td>NR</td>
<td>NR</td>
<td>Boston shelters</td>
</tr>
<tr>
<td>Bassuk, Rubin, &amp; Lauriet, 1986</td>
<td>80</td>
<td>0.0</td>
<td>3.0</td>
<td>10.0</td>
<td>NR</td>
<td>4.0</td>
<td>Boston shelters</td>
</tr>
<tr>
<td>Bassuk &amp; Rosenberg, 1988</td>
<td>49</td>
<td>0.0</td>
<td>6.1</td>
<td>2.0</td>
<td>NR</td>
<td>NR</td>
<td>Boston shelters</td>
</tr>
<tr>
<td>Breakey et al., 1989</td>
<td>203</td>
<td>62.0</td>
<td>10.5</td>
<td>21.7</td>
<td>2.0</td>
<td>14.4</td>
<td>Baltimore shelters and jail</td>
</tr>
<tr>
<td>DIS (or modification)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fischer, Shapiro, Breakey, Anthony, &amp; Kramer, 1986</td>
<td>51</td>
<td>94.0</td>
<td>2.0</td>
<td>13.7</td>
<td>7.8</td>
<td>15.7</td>
<td>Baltimore shelters</td>
</tr>
<tr>
<td>Koegel, Burnam, &amp; Farr, 1988</td>
<td>328</td>
<td>99.0</td>
<td>13.1</td>
<td>29.5</td>
<td>3.4</td>
<td>20.8</td>
<td>Los Angeles shelters and services</td>
</tr>
<tr>
<td>Vernez, Burnam, McGlynn, Trude, &amp; Mittman, 1986</td>
<td>315</td>
<td>71.0</td>
<td>11.0</td>
<td>22.0</td>
<td>NR</td>
<td>NR</td>
<td>California shelters and street</td>
</tr>
<tr>
<td>Toro &amp; Wall, 1989</td>
<td>76</td>
<td>79.0</td>
<td>1.4</td>
<td>15.1</td>
<td>14.5</td>
<td>37.1</td>
<td>Buffalo shelters and street</td>
</tr>
<tr>
<td>Regler, Boyd, &amp; Burke, 1986</td>
<td>18,571</td>
<td>41.0</td>
<td>1.3</td>
<td>8.3</td>
<td>1.3</td>
<td>2.5</td>
<td>U.S. ECA households (5 cities)</td>
</tr>
</tbody>
</table>

*Note. DSM = Diagnostic and Statistical Manual of Mental Disorders, third edition. NIH = National Institute of Mental Health. ECA = Epidemiologic Catchment Area. DIS = Diagnostic Interview Schedule. NR = not reported.*

Reproduced from Fischer and Breakey, (1991, 1122)
VITA

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The scope of this study is three-fold. I begin in Section I by attempting to lay a discursive foundation for talking about madness and mental illness. I attempt to trace out both a moral and a medical-scientific discourse of madness, beginning in Plato and continuing to the present. I examine the claims of Foucault that modern psychiatric practice is overlain with the “myths of objectivity and neutrality” by examining some of the contemporary discussions over mental illness. In Section II, I continue my investigation into the discursive formation of madness by examining our contemporary understanding of the ‘homeless mentally ill’ in the United States. My main argument is that the most prevalent mental disorders found among the homeless are those which are moral and not clinical in nature, and that this shows that the claims of observer-objectivity and value-neutrality in mental health are likely false. I continue my investigation into the discursive formation of madness in Section III by uncovering two distinct discourses of madness in the work of Plato. I argue that there are two distinct forms of madness in Plato, only one of which meets the criteria of mental disorder found in the DSM.

Findings and Conclusions:

Our contemporary understanding of homelessness has been shaped in a significant way by the re-formation of a medical-scientific discourse of madness in the form of the biomedical model of psychiatry in the last two decades. It is concluded that the reason prevalence rates of ASPD among the homeless are significantly inflated is due to a diagnostic bias that results from the medicalization of typical homeless behavior. Thus, it is concluded that the claims of objectivity and neutrality of the biomedical model of mental illness should be dismissed. Finally, it is concluded that there are two distinct forms of madness in Plato which provide us with two different yet important ways of speaking about madness. I conclude by pointing to a positive problematization of madness through a collection of groups and organizations that adopt a ‘harm reduction’ strategy in a social justice framework.

ADVISER’S APPROVAL: Dr. Mike Taylor