

# “That proves you mad, because you know it not”: impaired insight and the dilemma of governing psychiatric patients as legal subjects

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**Abstract** This article investigates “impaired insight,” a controversial psychiatric category describing a mad person unable to know his or her madness. Like “moral insanity” and other concepts before it, impaired insight offers a way to link the disparate logics of human responsibility in psychiatry and the law. I attribute its development to changes wrought by deinstitutionalization, the rise of antipsychotic medication, and patient incarceration in penal settings. In a system that aims to govern psychiatric patients through their freedom, the logic of impaired insight introduces a wrinkle: can a person make an informed choice to refuse treatment if madness itself impairs awareness of illness? Drawing on tools from the sociology of science, I trace the process by which researchers recast psychodynamic “denial” as a neurological and therefore non-volitional “impairment” in the 1990s. I then show how social movement actors mobilized the materialized form in the legal and policy fields in the 2000s, bringing insight science to bear upon the very questions of custodial management and patient rights that gave birth to it. At stake is this dilemma: how can societies that simultaneously privilege individual responsibility and somatic accounts of behavior govern those at the border of legal capacity, and with what justification?

**Keywords** Anosognosia · Criminalization of madness · Knowledge and power · Liberal governance · Medicalization of deviance · Psychiatry and the law

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Candido: What? Am I mad, say you, and I not know it?

Officer: That proves you mad, because you know it not.

- *The Honest Whore*, Thomas Dekker 1604

A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed anosognosia.

- *Diagnostic and Statistical Manual IV-TR*, American Psychiatric Association 2000

When the Unabomber Theodore Kaczynski went on trial for murder in 1997, he famously refused his legal team's insanity defense and sought to represent himself. To override this action his defense team mobilized a curious discourse, informing the judge that he suffered from "anosognosia"—a neurologically based impairment of insight into his condition. By denying his madness, they argued, Kaczynski merely affirmed it. Faced with a trial where his attorneys would portray him and his anti-technological manifesto as insane, Kaczynski accepted a life sentence in prison. Philosopher-journalist Alston Chase (2000) denounced the logic of the defense in an extended piece in the *Atlantic*, writing, "a refusal to admit to being insane or to cooperate with people who are paid to pronounce one insane cannot be taken seriously as proof of insanity." Like Joseph Heller's (1961) fictional pilots proved healthy when claiming to be too ill for combat, Kaczynski was in a "catch 22." Yet while impaired insight remains contested in both legal and psychiatric circles, it has become a crucial concept bridging knowledge and power in medical research, clinical care, legal cases, and mental health policy.

Consider this 2014 statement to the House floor from Representative Timothy Murphy of Pennsylvania, introducing the "Helping Families in Mental Health Crisis Act" H.R. 3717:

We know fifty percent of persons with schizophrenia suffer from a neurological impairment that makes them incapable of understanding they are ill. This lack of awareness, termed anosognosia, is the leading cause of noncompliance with psychiatric treatment. This neurological problem helps to explain why forty percent of Americans with a serious mental illness do not receive treatment, and it explains how our system fails to help those most in need (Murphy 2014).

Note the micro-macro linkage tying the failure of the mental health *system* to patient non-compliance, and non-compliance to lack of insight. Although Murphy's bill was controversial for perceived attacks on patient<sup>1</sup> civil liberties, a renewed version passed through

<sup>1</sup> A note on terminology: I use the word "patient" out of convention, but acknowledge it is hardly neutral. The proliferation of terms such as "client," "consumer," or the critical "c/s/x" (consumer/survivor/ex-patient) points to the unsettled politics at hand. Similarly, I recognize that "madness," "psychiatric disability," and "mental illness" often denote competing ontological commitments. I vary usage relative to the historical context and with respect to the multiple perspectives presented.

Congress with broad bipartisan support and was signed into law in 2016. How had this paradoxical logic, the very embodiment of a “catch 22,” come to circulate in scientific and policy discourse?

Michel Foucault opened his *Abnormal* (2003, p.6) lectures at the College de France with a similar empirical puzzle. Analyzing mid-twentieth-century criminal psychiatric evaluations, he asked how such ideas could be taken seriously when they met neither the standards of medical nor legal inquiry. To explain the present state of knowledge, he returned to the founding problem of nineteenth-century forensic psychiatry: how to judge a monstrous, seemingly mad crime when the defendant did not meet the strict standards of delusion. He argued that ideas like “instinct,” “moral insanity,” and the speculative psychoanalysis of criminals could only be understood as part of a longer historical transformation of power that shifted the locus of social control from people’s acts to their potentialities, opened a space of knowledge between the medical and juridical fields, and constructed the figure of the “dangerous individual.”

Impaired insight, I show here, is the latest attempt in a history of “reiterated problem solving” (Haydu 1998) to address a seemingly intractable dilemma: how to govern psychiatric patients who are also legal subjects. Like similar concepts before it, impaired insight is an attempt to create a durable link between psychiatry and law and mediate their respective visions of human responsibility. Critics of insight science have dismissed it as scientifically unfounded or the mere medicalization of patient dissent. My goal is to account for the emergence of impaired insight as a scientific object, its linkage to compliance behaviors, and its translation into the legal and policy fields.

I orient my empirical analysis around two interrelated empirical puzzles:

1. How and why did denial of illness emerge as an object of sustained psychiatric inquiry in the 1970s, given that awareness of madness had long been noted as a variable dimension of psychosis?
2. How and why did the concept, reframed as “impaired insight,” become relevant to American law and policy in the 2000s, given longstanding interest in reform of commitment procedure vis-à-vis patient competence?

The logic of my answer proceeds as follows:

The shift in psychiatric patient management from institutional confinement to community care created a host of new practical problems, drawing attention to psychiatric outpatients’ legally empowered refusal or failure to self-govern in prescribed ways. Here scientists became interested in poor insight as a mediator of outpatient non-compliance, but the apparent agency contained in the psychoanalytic theory of denial left it ill-suited for translation into a legal paradigm predicated on volition. With the shift from psychoanalysis to biological psychiatry and development of new representative technologies, however, researchers rendered poor insight scientifically measurable and visually perceptible as material pathology within the brain. With this materialization in the 1990s insight became a “boundary object” (Star and Griesemer 1989) linking psychiatry, neurology, law, and policy, enabling new possibilities for translation in legal proceedings and civil commitment reform. A powerful new social movement of patient family members enrolled researchers, legal scholars, and policy

makers to bring insight science to bear upon the very dilemmas of liberal governance that gave birth to it.

“Impaired insight,” then, is a device that translates and coordinates the interests and actions of mental health professionals, legal experts, and family advocates after the changes wrought by deinstitutionalization.<sup>2</sup> It can only be understood within a historical transformation of power, most clearly articulated in the United States, which shifted control of mad people from governance over their freedom to governance through their freedom (Rose 1999), and the development of technologies of management—antipsychotic medications—that could ostensibly facilitate this self-governance. The power of the impaired insight concept is to make illiberal interventions appear consonant with the civil liberties institutionalized in the twentieth century. If compliance with a medication regimen can reconstitute a person’s Reason and knowledge of their illness, then coercive care may equip that person with the knowledge and wherewithal to make future treatment decisions freely.

To echo Valverde’s (1998) writings on choice and determinism in theories of alcoholism, the case of impaired insight is not merely the story of a medical problem, but of a paradox at the center of liberal governance. This paradox is that human beings are born free, but must also be made free (see Hindess 1993). If advanced democracies aim to govern populations through their free choices, then impaired insight marks a profound point of tension—and possible escape valve—for the dilemmas of neoliberal order.

At stake is the question of how societies that simultaneously privilege individual responsibility and somatic accounts of behavior will govern those at the border of legal capacity, and with what justification.

The current attempts at US mental health reform must respond to the brutal legacies of both the asylum and deinstitutionalization, with new practical problems, institutional constraints, powerful social movements, and technologies. My analysis here shows how impaired insight emerged in the structural and cultural contradictions of its time and then became attractive as a potential resource for resolving them. To extend the genealogical analysis of forensic psychiatry to today, however, requires tools for a world Foucault did not live to see. In the next sections I first review the literature on knowledge, psychiatry, and the law, and then describe the methodological approach suited to analyzing the new material psychiatry and its translation.

## Governing the will in psychiatry and the law

How can we account for the knowledge produced and power exercised at the intersection of psychiatry and the law? Although even ancient legal systems had provisions to render some people unaccountable for their actions, Western courts only began to regulate the attribution of madness in the nineteenth century (Smith 1981; Eigen 1995; Skålevåg 2006). For the sociology of professions, this is a founding story of conflict between the two great professions—medicine and law (see Abbott 1988)—seeking greater influence and monopoly of a territory. Where law operated on an assumption of human action as volitional, doctors sought mechanistic explanation of behavior. In

<sup>2</sup> I thank Gil Eyal for this clear and succinct phrasing.

Smith's (Smith 1981, p.72) account of Victorian insanity trials, "Medico-legal conflict was therefore inevitable." If Smith saw the expanse of medical knowledge as an attempt at usurpation, Eigen (1995) emphasized the role and interests of defense attorneys, who pulled doctors into the fold for their own purposes. Yet by posing the question as one of *conflict between professions*, such an approach can gloss other dynamics at play.

As Skålevåg (2006) points out, both versions of this sociology of professions assume "interest" as a primary causal factor when those interests themselves were still cohering. Following Goldstein's (2001) reflections on her professions-oriented approach to French psychiatry, we can profitably read the story of *lawyers* and *doctors* alongside the story of *law* and *the disciplines*. For Foucault (1980), forensic psychiatry might be analyzed as a "strategy without a subject" that requires analysis of a broader reconfiguration of sovereign and disciplinary power. Presaging Eyal's (2010) call for a sociology of expertise rather than professions, Foucault offers a discursive history of medico-legal thought as irreducible to the interests of either doctors or lawyers.

In Foucault's (2003) analysis of the French case, the introduction of psychiatric knowledge to the court was not merely the attempt of the doctors to colonize professional territory, or defense attorneys seeking to win particular cases. Instead, jurists were demanding this medicalization to ensure the legitimate functioning of the law itself under changing regimes of power. The crucial problem for judges was what to do with the monstrous crime "without motive." The legal use of John Locke's vision of madness as defect of the intellect made it extremely difficult for doctors to convince judges of insanity (Berrios 1996). In a system that increasingly sought to make the punishment fit the *criminal* rather than merely the crime, how could one properly punish seemingly irrational actions that did not meet standards of madness requiring delusion or dementia?

The solution was concepts like "moral insanity," "monomania," and "instinct" that could account for madness of behavior without evidence of compromised intellect. These ideas helped decouple madness from delusion, allowing the law to punish the reasonable and confine the unreasonable to the asylums. Thus, the lower-threshold medicalization of illegible crime and the practical solution of asylum confinement helped to effectuate the smooth functioning of the law. This solution was only temporary, however, for there were other seemingly mad crimes that the state *did* want to punish. In a sensational 1880s case followed by psychiatry at large, the United States put Charles Guiteau on trial for the assassination of US president James Garfield. During this case, the language of moral insanity came under attack as unscientific and belonging more clearly to the legal realm (Rosenburg 1968).

Could psychiatric and legal thinkers develop a shared vocabulary to ferret out imposers and ensure the punishment of crimes unforgivable by the state? The answer was a resounding "no." At a 1909 meeting of the American Institute of Criminal Law and Criminology, a committee of prominent legal and medical practitioners met to rework the language of insanity. Yet after ten years of debate they could merely agree to disagree. In Tighe's (2005) apt anthropological metaphor, early-twentieth century psychiatrists "gifted" the concept of insanity to the law in a process of symbolic boundary work that helped their overall professional struggle to reconstitute psychiatry as a medical science. Forensic psychiatry was subsequently defined by the difficulty of reconciling legal and medical conceptions of human action and responsibility, and rather than share language, "... fluency in two disparate ones, is the mark of mastery in this field" (Tighe 2005). The

nineteenth century history of civil specialties, such as last will and testaments, shows a similar use of medical expertise to explain low-level deviance before the judiciary returned to an autonomous legal definition of competence (Blumenthal 2006).

In the mid-twentieth century, deinstitutionalization destabilized what little common ground there was left between psychiatry and the law. As social scientists (e.g., Goffman 1961; Scheff 1966), philosophers (Foucault 1965), and even psychiatrists (Szasz 1964; Laing 1967) attacked the rehabilitative veneer of the asylum and intellectual foundations of psychiatric knowledge, legal theorists reformulated the old dilemma: How should mad people be conceived legally if there were no such thing as mental illness? For libertarian anti-psychiatrists like Szasz (1964), the solution was to simply grant them full legal status. If liberal thinkers since Locke and Mill had taken the mad as an exception to the expansion of rights, these civil libertarians aimed at logical consistency. States in turn institutionalized new regimes of protections for patients, moving from a “need for treatment” to “danger to self or others” criteria for coercive care (Appelbaum 1984).

Beyond the discourse and logic of liberty, however, there was a powerful structural undercurrent. As Scull (1977) noted, ideals of freedom and clinical faith in emerging medication regimens might be better understood as ideological window dressing. From his neo-Marxist perspective, deinstitutionalization was a consequence of the fiscal crisis of the welfare state, and governments were only too happy to close the expensive hospital systems. The material reality of a reduced hospital infrastructure and underfunded community care system soon posed a different dilemma: if a person was found to be incompetent in civil or criminal terms, where could one put them without asylum beds? In his later reflections, Scull (1989) noted that patients were free from the discipline of long-term hospitalization, but they were also abandoned in the community or incarcerated in penal settings. When President Reagan's would-be-assassin was sent to the hospital rather than prison, Congress passed new barriers to the federal insanity defense and several states eliminated such pleas entirely (see Caplan 1984). In Rose's (1999) influential terms, patients would henceforth be governed *through* their freedom, free to be judged as responsible like anyone else.

What could create a durable link between psychiatry and the law after states institutionalized civil liberties for mad people, restricted insanity pleas, and defunded the hospital infrastructure without providing adequate community services? One answer, I show here, is the concept of impaired insight. Like Foucault (2003), I begin with the puzzle of a seemingly illogical discourse that has nonetheless gained currency in power struggles of immense consequence. Unlike Foucault, I encounter a material object quantified in scales and localized in the brain with fMRI scans. To account for this requires a set of empirical tools that can address a world and scientific “regime of perceptibility” (Murphy 2006) that he did not live to see. Beyond the analytic levels of forms of power, institutional fields, and professions, then, I must reconstruct the technical work done to render impaired insight visible in the brain. I next turn to my methodological approach and the sociology of science, knowledge, and technology.

## Methods and data collection

The argument relies on historical materials, including scientific journal articles, standardized medical scales and measures, law review articles, case law, blogs, websites of

organizations, popular news media, and legislation. Following methodological developments in the socio-historical study of science, I aimed to unravel concepts and expertise that have been “black boxed” (Latour 1987), or rendered invisible by their own success and smooth functioning in technical and practical projects. As Eyal (2013, p. 871) has described it, the construction of scientific facts and expertise may be seen early on, when “alternative devices, actors, and arrangements are still viable candidates for formulating the problem or addressing it.” After this period of visible contingency, however, scholars must begin with the reified concept and work backwards, so that the

... process of ‘black boxing’ and standardization can be reversed to trace the other actors (even if they do not control any identifiable part of the task at hand), equipment (especially transcription devices), institutional and spatial arrangements, and concepts of which a form of expertise is composed (2013, p. 872).

After first tracing the black boxing of, say, a psychological scale to the conditions under which the scale was constructed and used, I next followed where the black box traveled and whether the meaning of the measurements changed with new uses.

Within my overarching analysis of the “reiterated problem” (Haydu 1998) of governing psychiatric patients as legal subjects, I draw on the Foucaultian notion of “problematization” and a more general pragmatist orientation (e.g., Tavory and Timmermans 2014) to problem solving in everyday life. To better understand how problematizing objects of *thought* connected to practical problems, I scanned scientific and legal documents for the ostensible reasons for the research or legal intervention. Thus, I attempted to reconstruct how changes in the law, clinic, and lab affected each other through changing problem dynamics.

While quantitative approaches to diffusion can powerfully show how a singular concept travels across fields, it is precisely the object’s transitions and stabilizations in relation to larger societal dynamics that are at stake here. Given that the phenomenon has alternately been formulated as “impaired insight,” “the wish to be crazy,” “denial,” and “anosognosia,” I read all materials closely to trace the connections among disparate terms and avoid conflating distinct approaches that share keywords. Psychoanalysts, for instance, frequently address “insight” as self-knowledge in general, and neurologists often discuss “anosognosia” in reference to stroke victims, so keyword search counts can be misleading. I therefore follow Latour (1987) in tracing *translations* rather than *diffusion*, for the assumption that a stable entity diffuses between pre-constituted social actors can obfuscate the way both the entity and the actors are themselves unstable and sometimes reconstituted in the process.

I began by searching PubMed and Google Scholar for the terms “insight” and “psychiatry,” and then possible synonyms like those above and associated concepts (e.g., “non-compliance”) that emerged as the analysis developed.<sup>3</sup> I scrutinized texts for the context and the meaning of those terms, and coded them by theoretical orientation and method (e.g., psychodynamic versus biological, case study versus statistical) and

<sup>3</sup> A key tension in studying scientific literatures is that the corpus may actually be too large for an individual to read, yet change in such ways over time that textual analysis is preferable to citation analysis (see Kelty and Landecker 2009). Theoretical filtering becomes necessary when a term like “insight,” as a simultaneously lay and scientific word, has 122,940 entries on PubMed alone. I thank Hannah Landecker for suggesting I follow the psychological scales as an orienting strategy.

publication date (see Armstrong 2009 for a similar genealogical approach with scientific databases). By mapping the references by time, theoretical approach, and valence, I could see, for instance, that scientists in the 1990s continued to invoke the psychoanalytic denial theory, but in a *negative* rather than positive light. When I found scientists claiming a conceptual breakthrough in the turn to neurology in the 1990s, I searched neurological journals for the analogy between poor insight and “anosognosia” in earlier periods to see if such a thing had been previously thinkable. This revealed that in 1974 a neurologist had already considered the analogy *but rejected it*, another situation where citation or keyword counts might miss the meaning at hand.

In regards to relevant law review articles, case law, and briefs, I performed similar operations with the legal database Westlaw and Google Scholar, coding documents both inductively and deductively by the notion used, the kind of legal argument in which it was deployed, and time period. I found blogs, advocacy group statements, and other texts through Google searches. In other cases I identified key authors and combed through publication records for expert statements occurring outside of the bounds of academic, professional, or legal spheres.

### **Problematizing insight: Outpatient drug refusal and the “wish to be crazy”**

In this section I show how the mid-twentieth century solution to the dilemma of governing psychiatric patients as legal subjects—deinstitutionalization and treating them as nearly equal before the law—gave rise to a new series of dilemmas, such as patient “non-compliance,” homelessness, and criminalization. In this new problem space, the question of patient *insight* became legible as a way to understand patient *choice*. Yet the notion of insight also has a folk history that far predates its conceptualization in the 1970s. Although a full institutional accounting is beyond the scope of this article, it is useful to begin with these early statements as they can help illustrate the specificity of the twentieth century transformation.

The notion of the putative mad person unaware of madness has been in circulation for some time, as evidenced by the character Candido in Dekker’s 1604 play “The Honest Whore” (Dekker 2010). For seventeenth century thinkers like Hobbes and Locke, a delusional person aware of delusions constituted a logical contradiction, with a lack of insight essentially definitional to madness (Berrios 1994). Late-nineteenth and early-twentieth century theories allowed for a degree of patient self-knowledge, with Kraepelin (1917) viewing some dementia praecox patients as partially aware of illness before descending into further madness, and Lewis (1934) offering a notable definition of insight as “correct attitude toward morbid change in oneself.” Researchers expressed empirical interest in insight in relation to the problem of “post-psychotic-depression,” observing that once patients gained full understanding of their madness they were forced to reckon with the dour reality of the situation (see Mayer-Gross 1920, as cited in Mcglashan-Carpenter 1976).

Consider that the mad people of Dekker’s era were treated as a domestic or local parish problem, for there were no asylums to speak of. Hobbes and Locke wrote in the earliest years of the English asylum, and took for granted that such people required paternalism. That lack of insight was definitional to madness was derived from first principles and speculation, for they lacked the raw empirical materials for observation.



It was not until the “great confinement” (Foucault 1965) of the seventeenth century that the poor, unemployed, mad, and other deviants were brought into hospitals, and not until the nineteenth century that medical doctors would use these patients to observe, classify, and theorize a science of mental illness.

When Kraepelin, Mayer-Gross, and Lewis were writing in the late nineteenth and early twentieth century, mad people throughout Europe and the United States were largely held in asylums. To situate the relation of insight to “post-psychotic-depression,” consider that patients of the early twentieth century would exit a psychosis and likely be confined in a total institution. It is perhaps unsurprising that clinicians and researchers saw individuals gain “insight” into their situation and find it depressing. For the burgeoning discipline of psychoanalysis, “insight” was defined as understanding of unconscious dynamics more broadly. With its focus on wealthier, voluntary outpatients, psychoanalysis paid little attention to psychotic illness awareness in the incarcerated mad population. For asylum caretakers, psychodynamic thought offered little practical advice for custodial management of large wards. Still, it provided a language to serve that purpose eventually, for it placed a new emphasis on the subjective thought processes of the patient.

By the 1970s, psychiatric researchers found patient understanding of illness increasingly problematic and linked to a new object of interest beyond post-psychotic-depression. The first major publication in this vein, Van Putten et al. (1976), theorized the new phenomenon of outpatient drug refusal as the psychodynamic “wish to be crazy” (cf. Geisen and Feuer 1984 on the “need to stay crazy”). Such authors psychoanalyzed patients’ delusions of health as an “ego syntonic” coping strategy, with awareness and medication adherence viewed as serious threats to a grandiose sense of self. Consider this case description of a young man who thought himself a successful aeronautical engineer until he began taking antipsychotic medication.

While receiving fluphenazine decanoate, 25 mg every two weeks, he was objectively globally improved; subjectively, he seemed to resent the increased reality contact.... He started to mention his loneliness and his realistic lack of any life accomplishments and developed some insight into illness. At this point, he demanded to leave the hospital and resumed living in a lonely hotel. He returned for only one injection of fluphenazine decanoate and was readmitted three months later, psychotic as before (Van Putten et al. 1976, p. 1446).

This appears similar to Meyer-Gross’s work fifty years earlier—the person’s growing awareness of madness threatened the self—yet the object of interest mediated by insight had changed. Upon developing insight, the young man encountered a depressing reality, but addressed this by simply leaving the hospital and avoiding his outpatient injection follow-ups. Where Meyer-Gross (1920) was concerned primarily with explaining why patients fell into *post-psychotic-depressions*, the researchers of the 1970s to 1980s investigated insight as the mediator of outpatient *non-compliance* with medication. What accounts for this?

Put simply, psychiatry’s institutional needs had changed following the mid-twentieth century restructuring of the Western welfare state, codified in commitment law and realized in wide-scale deinstitutionalization. The root cause of hospital closures may have been fiscal crisis (see Scull 1977), but the discourse was that of self-determination

and democracy. The burden of care was shifted from state governments to local communities and ex-patients themselves, who were granted both new rights to autonomy and financial independence from caretakers in the form of new Federal welfare programs like SSI and Medicare.

With the development of new medications that ostensibly controlled psychosis, people could conceivably direct treatment themselves. Outpatient medication consumption offered a new form of governance resonant with civil liberties, for unlike “compliance” with, say, an asylum worker’s orders, compliance with medication could putatively render a person free to make subsequent treatment decisions. Many caretakers were immediately skeptical of this self-determination, however, as some people simply refused to take the drugs. As Van Putten put it, “The reluctance of patients with schizophrenia to take their prescribed phenothiazines is the bane of the psychiatrist” (1974, p. 67). He cited recent urine colorimetric studies that found between 24%–63% of schizophrenic outpatients had taken less medication than prescribed, part of a growing sentiment that newly empowered patients were not choosing the proper course of action.

Where coercive treatment had been almost entirely within the discretion of mental health professionals, legislation such as California’s 1967 Lanterman-Petris-Short Act granted people considerable new rights to treatment decision-making (see Scull 1989). With this legal empowerment and discharge of patients who would likely have been institutionalized in the past, outpatient treatment compliance became a site of clinical, political, as well as scientific interest. As McEvoy et al. (1981 p. 856) wrote in an interview study of patient attitudes toward treatment,

The right to refuse medication is a legal right now being extended by federal courts to many voluntary and involuntary mental patients. However, *little is known of the insight* that chronically ill mental patients bring to the decision of whether or not to accept prescribed medication (p. 856, emphasis added).

This passage illustrates how changes in the legal structure generated a new problem area of patient management and with it a new domain of intervention.

Where Dekker recognized the mad who “knew it not” in 1604, Hobbes and Locke assumed that people could not know their own madness, and Mayer-Gross analyzed the institutionalized post-psychotic-depressive in the 1920s asylum era, clinical researchers of the late twentieth century encountered something new: the self-governing, drug-refusing psychiatric outpatient in denial of mental illness. Although the link between insight and non-compliance seems obvious today, this was contingent on both a transformation of power and the introduction of a technology offering self-directed care. The problem of “out-patient drug refusal” only became possible with legally empowered patient self-governance in the community and the reliance on antipsychotics as a tool of management. If previous interventions such as moral treatment or psychoanalysis involved an ongoing relationship between therapist and patient, medication offered the possibility of self-directed treatment. With the right to refuse care, psychiatric patients would now be governed through their freedom and rational self-interest.

The logic of democratization, so common to the institutional changes and social movements of the period, proved an awkward fit for the mental health infrastructure. Although many ex-patients transitioned smoothly into the community, and a politicized minority organized as “survivors” fighting an abusive system, others struggled to manage independently. Family members, with few resources from the state and suddenly stripped of formal power, were de facto tasked with helping to manage their now legally empowered relations. Treatment providers tried coercive measures like predicating benefit payments on compliance, but this was hardly a consistent solution (Estroff 1981). Urine colorimetric tests of medication levels allowed for a quantification of adherence, materializing compliance behavior as tractable, but what could providers or family members do if the person continued to refuse?

The ensuing crises helped birth the family member social movement and powerful advocacy groups that brought attention to the failures of community mental health care, who argued that ex-patients were “dying with their rights on” (Treffert 1973). Critics of the new commitment laws like Appelbaum and Gutheil (1979, p. 313) invoked Van Putten et al. (1976) in legal discussion, writing “Psychotic patients may often have no unitary “will” as the law conceives it, but rather fluctuate back and forth between mutually exclusive desires, unable to resolve conflicting wishes.” Yet this conception of will as “conflicting wishes” was unconvincing, as the rights of the mentally ill to choose had become a foundational case on which ACLU theorists were addressing institutional “enclaves” where the Bill of Rights had yet to be respected (see Walker 1999). Civil libertarian theorists like Morse (1982) argued specifically that the behavior of those deemed mentally ill was no less volitional than that of the sane, and that psychiatrists had no objective way of determining competency or dangerousness.

Despite the medicalization of insight, such discourse was not translated into the broader scientific, legal, or policy spheres. There are likely four interrelated reasons for this, two of which are directly in line with Morse’s (1982) comments: First, psychodynamic theory attributed significant agency and desire to mad people in their putative “*wish* to be crazy,” leaving insight ill-suited for translation into a legal paradigm that predicated capacity on volition. Second, insight had not been materialized into a measurable, scientific construct and was therefore of no more use than the existing legal concepts like capacity or competence. Third, the civil libertarian and ex-patient activists were largely unchallenged, as the family member social movement had yet to cohere as a serious force to be reckoned with. Fourth, there was not a political opportunity to galvanize the public, such as the string of killings by putatively mentally ill individuals that served as a flashpoint in the late 2000s. Such counterfactual thinking is necessarily speculative, but the logic will become clearer after the following empirical sections.

### **Making insight material: Rating scales, card sorts, brain scans, and stimulation**

Before insight could become a new solution to the dilemma of governing psychiatric patients with robust legal rights, it had to be made material. In this section I show how transformations in psychiatry enabled scientists to conceive of insight as neurological, see insight in the brain, and then intervene upon it. This somaticization required social construction in the most literal sense, with scientists working to build material theories

and representations out of an intuitive but slippery concept. Although scientists had materialized medication-compliance through the technology of urine testing, insight itself remained elusive. With the resurgence of biological psychiatry and the development of new measurement technologies, however, researchers saw a brain-centered conceptualization of insight as first possible and then scientific common sense.

Insight scientists created scales to render classification “liquid” (Lakoff, 2005) and transportable, utilized card sorting tests to localize cognitive functioning, and performed brain scans to produce visual representations of that localization. They then formulated a theory of poor insight as analogous to the unawareness of partial paralysis found in brain-damaged stroke victims. The statement from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) IV-TR (2000) schizophrenia section reads,

A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed anosognosia (American Psychiatric Association 2000, p.304).

How had such a statement become possible? Anosognosia, coined by Babinski in 1917, typically referred to unawareness of hemiparesis or cortical blindness that could be linked to a localized brain lesion. The neurologist Hinterbuchner (1974, p. 590) had in fact offered poor insight into psychosis as a negative demarcation of anosognosia's boundaries, stating “there is no justification for including under this term patients with no awareness of their cardiac disease or patients who are schizophrenic and have no insight concerning their illness.”

The first step in making insight material was the creation of validated and standardized research populations, for investigators could hardly administer neuropsychological testing or brain imaging until they had comparison groups of people with varying degrees of insight. Prior to the DSM-III, psychiatrists often theorized etiology with in-depth case readings of patients' lives and thoughts. The shift in scientific practice from case study analysis to standardization, statistical comparison, and materialization was hardly unique to the case of insight, but a general transformation of psychiatry as a field.

The institutional story of the DSM-III revolution overlaps with that of the previous section, for psychiatry's legitimacy crisis extended beyond asylum practices to its very scientificity. Social scientific studies demonstrating the poor reliability of diagnosis served as a serious black eye for psychiatry, and a growing coalition of biologically-oriented practitioners mobilized within the American Psychiatric Association to reorient the discipline (Luhrmann 2000). The “neo-Kraepelinians,” borrowing heavily from the rating scale procedures of psychometrics, turned to statistical methods to address the ongoing problem of diagnostic reliability (Kirk and Kutchins 1992). Even if construct operationalization was suspect, the main goal of the DSM-III was not *validity*, but *reliability* of diagnosis across raters.

Without biological tests for mental illnesses, investigators hunting for an underlying genetic, biochemical, or neurological etiology still use phenotypical and behaviorally oriented diagnoses with which to correlate somatic markers (Lakoff 2005). Standardization processes (Timmermans and Berg 1997) were crucial for justifying the

paradigm shift, and the tools of psychology, here the standardized and internally validated diagnostic scale, were central to psychiatric research. This was not merely an ideological shift, but also an institutional one, as funding mechanisms and education created a generation of researchers whose careers were tied to standardized scales for increasingly refined dimensions of symptoms and sub-diagnoses. As Bowker and Star (1999) note, the practice of researchers, clinicians, insurance companies, and governmental agencies become tethered to one another when such classificatory systems gain hegemony.

The Present State Examination (Wing et al. 1974), used by the WHO for schizophrenia research and authors like Van Putten et al. (1976), contained a small section with four questions regarding insight. In 1989 McEvoy et al. produced the Insight and Treatment Attitude Questionnaire (ITAQ), the first measure devoted solely to insight. Recall that McEvoy et al. (1981) had previously conducted an interview study on insight, but where that research was restricted to descriptive claims like “only 13 percent understood they were mentally ill” (1981, p. 856), the standardized scale enabled correlational findings like “... *degree* of insight was not consistently related to the severity of acute psychopathology, as measured on two structured scales” (1989, p. 43 emphasis added). With the ITAQ, McEvoy et al. made insight into a quantitative object, with *degrees* that could be measured against yet more standardized scales.

David’s (1990) Schedule to Assess the Components of Insight (SAI) introduced a likert scale to capture finer grained dimensions and conceptualized insight as consisting of three parts, namely recognition that one has a mental disorder, compliance with treatment, and the ability to re-label unusual events as pathological. Amador and Strauss (1990) developed the Scale to Assess Unawareness of Mental Disorder (SUMD), which further distinguished between awareness of symptoms and attribution. This distinction allowed for a person to be aware of an ostensible symptom, yet also “misattribute” that experience to something besides mental disorder. Both the SAI and the SUMD were considered breakthroughs for examining insight as multidimensional rather than dichotomous and providing more sophisticated measures to capture such dimensions.<sup>4</sup>

A close reading of these scales is important for illustrating what information is elicited in particular constructions of insight. Anthropologically minded clinicians have criticized the scientific operationalization of insight for failing to take culture into account, with Johnson and Orrell (1996) showing, for instance, that hospital discharge summaries in the UK more frequently label non-whites as lacking insight. Such controversy led others to propose alternative “narrative insight” measures (see Tranulis et al. 2009), and mainstream researchers to acknowledge the culture dimension. My concern is tracing how particular interests become embedded through the operationalization and production of insight research, whether bio-psychiatric or “culturally sensitive” measures are at play. Rather than dismiss these scales as a case of informational “garbage in, garbage out,” I instead analyze what specific concerns are medicalized through the evaluation process.

<sup>4</sup> Proponents of the insight research see in this major scientific progress. As Torrey and Kress (2004, p. 38) put it, “The availability of instruments that can be used to measure anosognosia in large groups of patients has advanced this research area rapidly.” I would go further: the entire edifice of impaired insight research, and its subsequent translations, is predicated on these scales. Whatever it is the instruments actually measure, they are the material bedrock on which the rest of the logic rests.

Consider the structure of the SUMD. In comparison with the four questions in the Present State Examination, the SUMD has twenty multipart questions addressing such phenomena as “awareness of unusual eye contact” (Amador and Strauss 1990). The first item asks, “In the most general terms, does the subject believe that s/he has a mental disorder, psychiatric problem, emotional difficulty, etc.?” (p.5). Three options, of “aware,” “somewhat” and “unaware” can be selected and incorporated into the score. Substantively, a vision of insight emerges that is consistent with David’s (1990) suggestion that compliance with treatment is a core component of insightfulness. Consider question 2, “awareness of the achieved effects of medication”:

What is the subject’s belief regarding the effects of medication? Does the subject believe that medications have lessened the intensity of his/her symptoms (i.e.) if applicable?

0 Cannot be assessed. (Note: ALWAYS code a “0” on any item as MISSING DATA)

1 **Aware:** Subject clearly believes medications have lessened the intensity or frequency of his/her symptoms.

2

3 **Somewhat:** Is unsure whether medications have lessened the intensity or frequency of his/her symptoms, but can entertain the idea.

4

5 **Unaware:** Believes that medications have not lessened the intensity of frequency of his/her symptoms.

Thus awareness of illness, and therefore “insight,” becomes explicitly associated with medication compliance. Built into the instrument is the assumption that psychiatric medication is indeed unambiguously useful for all patients. The notion of “attribution,” which follows the “awareness” component, demonstrates the epistemic certainty built into the test.

Given the neurological and metabolic side effects of antipsychotic medication, as well as doubts about long-term efficacy (see Whitaker 2011 for a highly critical take), such a question may disregard people’s legitimate reasons for medication skepticism. Critics like Kirmayer et al. (2004) have been quick to point out that terms like “misattribution” are extremely loaded, and Jones and Brown (2012) note the way this naturalizes clinical authority. Sociologists have long known that those labeled mentally ill lose credibility in discussing that putative illness (see Goffman 1961; Smith 1978), but my goal here is not critique. What my analysis of the scales and ensuing correlational research highlights is precisely *how* researchers have operationalized this culturally embedded concept, not only naturalizing clinical authority but also setting the stage for materializing it as a tractable object. This is the standardization component of the materialization process, for these instruments helped create the research populations that allowed insight scientists to look for associations with various somatic measures.

In a landmark paper, Young et al. (1993) administered the SUMD, the Wisconsin Card Sorting Test (WCST), the Verbal Fluency Test, and the Trail Making Test to 31 hospitalized patients diagnosed with schizophrenia. While neither the Verbal Fluency nor Trail Making tests were significantly correlated with the SUMD, performance on

the WCST was predictive of insight measures. Given the WCST's reputation as a "frontal lobe test," and the failure of the other tests to show statistical significance, the researchers proposed that poor insight was likely localized to frontal lobes and "executive functions." Young et al. began to draw the analogy with neurological disorders, framing alternative explanations of symptoms as "confabulations," which are thought to be *organic* disturbances of the frontal lobes. Consider how far this "confabulation" is from the "mad who know it not" or those with a psychodynamic "wish to be crazy." Rather than a stable concept *diffusing* across domains, insight was already changing in the measurement and materialization process.

Soon scientists turned to more expensive technological measurements like structural brain imaging in the comparison of differential insight populations. As Dumit (2004) has shown, the "decade of the brain" saw a substantial monetary investment in imaging, with scientists researching myriad behaviors and thoughts via brain scans. This representation and visualization is a powerful component of the materialization process, for the phenomena becomes legible, if underdetermined, to lay audiences. In the insight literature, a range of possible locations have been identified, at a level of granularity far smaller than the card sorting tests "frontal lobes" hypothesis. Although somatic correlates need not lead to medicalization, as in the "natural variation" framing of genetic correlates after the de-medicalization of homosexuality (Shostak et al. 2008), the institutional environment for insight was ripe for pathologization.

In 2000 the DSM-IV-TR schizophrenia sections, co-chaired by insight researcher Xavier Amador, featured the analogy with anosognosia. The subsequent twenty years produced hundreds of empirical studies addressing the somatic correlates of poor insight. Consider this review of the literature in an fMRI study highlighting the role of the central midline structures (Bedford et al. 2012):

... recent sophisticated structural imaging studies have revealed relationships with specific brain regions or with fronto-temporal white matter [13]. The majority have found evidence for a relationship between poorer insight and either volumetric reduction or thinning of various cortical midline regions, most towards the anterior (frontal lobe: [14] medial-orbital prefrontal cortex PFC: [15]; medial PFC: [16,17]; medial-superior PFC: [18]; anterior cingulate: [15,19]; paracentral lobule: [16]) but also the posterior parts (posterior cingulate: [12,19]; precuneus: [18,20]; [16]). Two studies found poorer insight to correlate with *increased* volume in anterior midline regions [21, 22] ....

Note that poor insight is associated with both thinning and increased volume of cortical midline regions, but such controversy over *where* and with *what effect* are less important than the robust finding *that* insight (as measured by various scales) can be seen in the brain.

These sorts of brain mappings next enabled the possibility of somatic manipulations of poor insight, borrowed from neurological theory, which materialized insight in practice. Consider Levine et al. (2012), an experiment published in *Brain Stimulation* that took the DSM-IV-TR analogy between poor insight in psychosis and anosognosia for hemiparesis as a literal one, using a somatic treatment for stroke patients in psychiatric populations. The experiment attempted to improve insight among schizoaffective patients by placing cold water in their ears, as this has been known to improve awareness of partial paralysis

for anosognosiac stroke victims. The study produced ambiguous results, but more important than the outcome, the publication highlights how scientists made insight tangible. Built from scales, localized by card sorts, and visualized in brain scans, scientists now believed they could touch insight through the ear canal.

### **Translating insight: Family care, self-governance, case law, and policy reform**

Now rendered material, transportable, and institutionally validated by its inclusion in the DSM IV-TR, advocates began mobilizing impaired insight to address the dilemmas wrought by deinstitutionalization. By the turn of the century such quandaries of choice and authority had begun to shift under changing structural conditions. Beyond debates over the impact of civil liberties to refuse care and the underfunding of community services, analysts and advocates increasingly recognized the intertwining of two material realities: the continued decline in state hospital beds and the rise of hyper-incarceration. Where there had been 559,000 hospital beds in 1955, there were only 59,403 in 2000, and now an estimated 309,997 people with serious mental illness in penal settings (Lamb and Weinberger 2005). Although not necessarily implying a direct substitution of populations, the correlation was striking. As a 2005 PBS Frontline special put it, prisons had become “The New Asylums.” How could civil libertarians make sense of a system that protected patient rights to refuse hospital care, yet restricted rights through imprisonment? And if the laws were to be changed, where could authorities send people without an adequate hospital or community infrastructure?

In this section I focus on the *translation* of insight research into family mental health care, patient self-concept, legal scholarship, case law, and policy debates over outpatient commitment and legal culpability, where it has been most thoroughly embraced. Here “translation” describes how facts are stabilized and reconstructed across social fields and used to enroll seemingly disparate actors in shared projects (Callon 1986; Latour 1987). Impaired insight became a “boundary object” (Star and Griesemer 1989) that could mediate between actors addressing different dilemmas at different scales. Flexible enough to suit local needs yet robust enough to coordinate action, impaired insight allowed vocabularies from such disparate fields as medicine, law, self-help, and policy to enter into dialogue.

Strikingly, the bench science was not translated into clinical, somatic interventions aimed at restoring compromised insight, but primarily into behavioral therapies targeted at caretakers and policy prescriptions regarding commitment law. In this milieu the “mad who know it not” aren’t willful drug refusers with a “wish to be crazy,” but neurologically damaged subjects with deficits to be managed or remediated, like traumatic-brain-injury patients. Given researchers’ failure to produce any significant somatic clinical interventions, actors from other fields might have ignored or dismissed insight discourse. On the contrary, it has continued to grow, in large part due to social movement actors like the National Alliance on Mental Illness (NAMI) and the Treatment Advocacy Center (TAC), which have each adopted the anosognosia concept in their pamphlet literatures pertaining to involuntary commitment.

Standing opposed to the ex-patient activists and ACLU, such organizations are composed largely of family members and professionals. Emerging in the wake of



deinstitutionalization, these groups sought to penetrate the institutional logics of psychiatry and the legal system, both by equipping lay actors with expert knowledge, and hiring experts to act as brokers (see Epstein 1996 on HIV science). NAMI is a powerful advocate of bio-psychiatric logics, with critics calling attention to the fact that the pharmaceutical industry supplies a majority of its funding (Rothman et al. 2011). Beyond penetrating the psychiatric field, NAMI also enrolled legal scholars and litigators who would devote their careers to mental health reform. The TAC, run by psychiatrist E. Fuller Torrey, more directly sought to influence legislation for coercive care. In fact, these social movement actors are at the center of the network developing and translating the insight research into law and policy.

Rather than simply *recruits* to the family member agenda, some of the major developers of impaired insight were in fact *family members* involved with NAMI. The insight researcher Xavier Amador became a champion of the new knowledge, simultaneously acting as DSM-knowledge-gatekeeper, family advocate, expert witness, and moral entrepreneur. Amador was long aligned with the family member groups, identifying as the brother of a man who refused treatment and claimed not to be ill (Amador 2000). After the publication of DSM-IV-TR he moved further outside of the academic realm, consulting in legal cases including the Unabomber trial, writing popular texts, and offering commentary on news shows. By the early 2000s he was leading NAMI's Center on Practice and Research and later served on the Board of Directors.

Amador's (2000) best-selling book for family members and clinicians, entitled "I am not Sick, I Don't Need Help!" is a key text for understanding the diverse manifestations of insight knowledge outside of the expert domain. In a telling anecdote of the book's popularity, anthropologist Brodwin (2012) reports outpatient psychiatric staff instructed him to read it prior to conducting his fieldwork. Conceding the intractability of anosognosia, Amador's regimen is not a targeted intervention for the patient so much as a reorientation for caretakers, whose own irrationalities are subjected to analysis. Once they accept that they *cannot* convince patients of illness, caretakers are free to rationally assess what *can* be changed. In contrast to the expected focus on normalization, Amador advocates a surprising tolerance of strange behavior, precisely because patient subjectivity and resistance are thoroughly medicalized.

Although some psychiatric service users have reacted to the insight concept with skepticism and indignation, others use it as a resource for making sense of their lives. This appears paradoxical, for if anosognosia prevents the knowledge of mental illness, how can one then be knowledgeable about mental illness impairing that knowledge? Yet as Novas and Rose (2000) have argued in their work on "somatic individualism," people may respond to deterministic discourses with new ethical practices for monitoring and regulating their selves rather than resignation. Consider this (2012) blog post from Bipolar Mermaid, a woman who identifies herself as having impaired insight, and a reader's response:

Blogger 1: Anosognosia is the term for the most dangerous symptom of mental illness...I know consciously that going off my meds would be a bad idea, but because of this symptom, the concept seems perfectly reasonable. Unlike many others, I have the sense to discuss my plan with my loved ones.

Blogger 2: Hello, a name for why I am delusional about medication ... All I ever do is humiliate them [family] with my crazy bipolar Anosognosia. Stopping my

medication to get “ME” back, focused, intelligent, organized and successful with relationships. (This person never really existed that is the delusion).

For these bloggers, the classification enables a reinterpretation of identity and past experiences. That the first is equipped with enough “sense” to discuss this anti-medication plan with her loved ones suggests an ethical responsibility of vigilance. She has come to see some of her free choices as potential symptoms and her own volition as compromised and dangerous. The second can now see that her sense of self as healthy before medication was a delusion. Yet like Valverde’s (1998) analysis of alcoholics who admit their powerlessness over alcohol as the first step in recovery, this can become empowering. Rather than resigned to self-deluded madness, each is able to see her “choice” to go off of medication as a sign of anosognosia. From there, these women might try to stay medicated with mundane compliance techniques, protocols with loved ones, and the inculcation of habits below the realm of reflective thought.

If these bloggers saw an opportunity to gain volitional traction on their own madness, legal scholars drew on the new insight research to argue that patients lack the volition required of legal subjects. Such jurists have embraced the impaired insight research to address two persistent points of contention in debates over involuntary commitment, such as those posed by Morse (1982). The first revolves around the question of how to ensure citizens maximum liberty, and the second involves the problem of subjectivity and error in competence evaluation. Responding to court decisions that view compulsory treatment as an impingement on liberty, Davoli (2002) utilizes the insight research to argue that it is in fact *mental illness* that threatens freedom, not coercive care. By preventing a person from appreciating his or her condition, the symptom of poor insight redefines any notion of free will. Davoli, who has contributed to NAMI materials, writes,

Recent research reveals that denial or inability to accept that one is mentally ill is actually a symptom of the disease ... a brain defect that is telling him that he is not sick and that he must refuse treatment. In this way, the disease itself actually steals the afflicted individual’s free will (Davoli 2002 p.1007).

The metaphor of an external agent that “steals” free will from an autonomous self is key. Consider the difference with psychoanalytic denial theory, where an agent retains volition in his or her “wish to be crazy.”

In an article on the ethics of coercive care, Munetz et al. (2003) suggest that the impaired insight research might offer an objective determination for the “appreciation test,” a competence standard that asks whether a person can recognize the implications of his or her mental situation. Munetz et al. (2003 p. 175) write,

It appears that a patient who does not believe he/she is ill (i.e., who lacks insight) would fail the appreciation test and, on that basis could be found to lack decision-making capacity. Recent evidence suggests that this unawareness of illness has a neurobiologic basis.... In such cases, rights-based arguments appear

to give way to the notion of beneficence, using the *parens patrie* powers of the state to make decisions on behalf of individuals who are unable to make informed decisions for themselves.

Others soon claimed that insight measures could *replace* existing ways of evaluating competence.

University of Iowa law professor Kenneth Kress (2004), writing in a volume on insight edited by Xavier Amador, suggests that insight should become the standard by which courts assess capacity and justify involuntary commitment. Given that it “might be more determinately and precisely measurable, it is plausible that in legal applications lack of insight will command more inter-subjective agreement than competence...” (Kress 2004, p.270). Here the insight scales are put to work as the material bedrock on which Kress’s argument rests, an objective way to evaluate the free will and volition central to American law. Like Amador, Kress is affiliated with NAMI and was a member of the board of directors at the TAC.

With the publication of the increasingly sophisticated neuroscience research, jurists moved beyond the question of scales and measurement to direct evidence from brain-scan studies. Elizabeth Bennion’s (2013) “A Right to Remain Psychotic?” offers nearly two full pages of quotations from six neuropsychiatric studies claiming localizations of insight, emphasizing the triumph of the anosognosia research over denial theory. She then writes, “We are no longer respecting a person’s informed choice, rather we are protecting an inadequately formed delusion” (Bennion 2013, pp. 296). Here the materiality of insight as observable brain damage serves to compel new legal thinking.

This is not to say such ideas have gone uncontested. The appreciation test, for instance, is far from a universally agreed upon competence standard, and other legal scholars have argued that the only acceptable test is “basic rationality” (Slobogin 1996). Elyn Saks (2012), a prominent law professor who is herself diagnosed with schizophrenia, has attempted a middle ground by claiming lack of appreciation requires not just impaired insight, but also “patently false beliefs.” Yet such intellectual resistance may merely point to the increasing prominence of insight science in law, for Saks notes numerous courts have found denial of mental illness *in and of itself* sufficient grounds for incompetence.

In courtrooms, lawyers and judges have further used the insight research to both affirm and dispute culpability. Successful insanity defenses are rare in America, and it is well established that somatic accounts of legal culpability are typically more relevant in sentencing than verdict (see Rose 2000). In civil cases, however, psychiatric expert witnesses have used the impaired insight concept as a potent force for assessing risk in cases to determine hospital release (see Keomany v. Comm’r of Human Services 2012) and the appropriate level of restrictive care (see Struck v. Cook County Public Guardian 2008). Perhaps less obviously, experts and judges have also used the concept to complicate the meaning of compliance, reframing what might look like malingering as a potential confirmation of illness and claims of illness and the need for treatment as proof of fakery. This is, once again, the very embodiment of “catch 22.”

Consider Collins v. Astrue 2012, an appeal of a dismissed disability claim. The administrative law judge who first evaluated the case noted the claimant had failed to take prescribed medications for schizophrenia, casting doubt on his disability and entitlement to benefits. The district court reversed this decision, invoking the insight

research to reach the opposite conclusion: the person in question had likely failed to take medication because of anosognosia for schizophrenia, therefore confirming mental illness and deservingness of disability benefits.

Consider next *Hursey v. Taglia* 2012, in which a state prisoner unsuccessfully brought civil rights charges against his psychiatric care providers. The plaintiff, Mr. Hursey, asserted that his antipsychotic prescription was discontinued as retribution for grievances he filed, that he was denied appropriate placement in a unit where he could receive care, and that this deliberate indifference violated his Eighth Amendment rights. Defendant Taglia testified that Mr. Hursey's insistence on his psychosis and need for medication confirmed that he was in fact a malingerer, undermining both claims. The magistrate judge's decision cites Taglia's statement that Hursey "... actively asserts that he is psychotic, which is contrary to the anosognosia that is the hallmark of major mental illness." Inverting the logic of the previous case, the knowledge of madness and desire for medication here confirm sanity and duplicity.

Although the precise impact of such information is difficult to discern, and judicial outcomes are further contingent on particular courts' organizational exigencies, these case examples illustrate the utility of the impaired insight concept in two major classificatory dilemmas of the neoliberal era: benefit provision through disability after the end of welfare-as-we-knew-it (see Dobransky 2009) and differential housing assignment in wildly overcrowded prisons (see Rhodes 2004). Rather than speculate on whether either plaintiff was in fact malingering, I instead note that impaired insight acts as a now materialized and institutionally legitimated conceptual resource for evaluating deservingness.

Use of the anosognosia concept has also moved beyond the confines of individual court cases to address nearly *all* actions that a psychiatrically disabled person might take. Proponents have mobilized the insight research to explain significant social problems, tying macro-level phenomena and potential policy solutions to the micro-level insight/compliance nexus. There is a striking function creep, with impaired insight accounting for just about everything that goes wrong in community mental health care. Fuller Torrey and Kress (2004) from the Treatment Advocacy Center offer a list of "consequences of anosognosia" that includes noncompliance with medication, relapse, homelessness, incarceration, and violent behavior.

H. R. Lamb's (2009) editorial in the prestigious *American Journal of Psychiatry* uses a similar logic to address the failure of deinstitutionalization and the current criminalization of mental illness:

A large proportion of persons with severe mental illness who have committed criminal offenses and are now in jails or prisons are found to be highly resistant to psychiatric treatment. They may refuse referral, miss appointments, fail to adhere to their medication regimen, engage in substance abuse, and refuse appropriate housing placements. Many of these persons suffer from anosognosia, a biologically based inability to recognize that one has a mental illness—and thus a biologically based lack of insight (Lamb 2009, p.9).

A respected psychiatric leader and former member of NAMI's board of directors, Lamb embraces the anosognosia analogy wholeheartedly, without the qualifiers found

in the DSM IV-TR phrasing, and moves beyond medication non-compliance to link a host of behaviors, interactions, and outcomes, to impaired insight. Like the previously mentioned Munetz et al. (2003) article on the ethics of civil commitment, Lamb concludes by suggesting that the best way to reverse the criminalization of mental illness is to expand involuntary options like “assisted outpatient treatment” (AOT), or court-mandated community care that can be initiated at lower thresholds than the “dangerousness” required for forcible hospitalization.

The AOT question became national news in the wake of numerous mass killings perpetrated by ostensibly mentally ill individuals. Consider the Sandy Hook elementary school shootings, where a young man gunned down twenty-six people. Less than a year prior, the ACLU defeated proposed AOT legislation that would have facilitated outpatient commitment in Connecticut. Proponents have suggested that the perpetrator might have been identified and detained had the AOT law gone into effect. The Hartford Courant, Connecticut’s largest newspaper, hosted an op-ed debate on AOT, framed specifically around the question of insight. While community psychologist Larry Davidson (2013) dismisses the insight research and focuses on “fixing the society, and system,” Xavier Amador (2013) suggests Davidson is scientifically ignorant. After invoking his own expertise in regards to the DSM IV-TR, Amador writes, “Anosognosia is real and AOT provides a workaround that can save lives.” Note how this translates anosognosia into a prescription for AOT policy.

Finally, we turn from policy debates to actual legislative attempts to overhaul commitment law. As noted in the introduction, Representative Timothy Murphy of Pennsylvania introduced the “Helping Families in Mental Health Crisis Act,” H.R. 3717, in 2013 and a revised version in 2016. The most controversial element of the original “Murphy Bill,” later debated and tempered in subsequent drafts, was a reprioritizing of mental health dollars for the national expansion of AOT. Murphy, as quoted earlier, justified this in reference to research on impaired insight for psychosis. Consider also the language of Maryland House Bill 767 (2014), a proposal for a new AOT program. Two clauses from the preamble are worth quoting at length:

WHEREAS, When individuals with anosognosia remain untreated, they suffer unnecessarily from homelessness, poverty, repeated arrests, trauma, and suicide; and

WHEREAS, When individuals with anosognosia remain untreated, they lack the capacity to make rational and informed decisions regarding their civil rights...

Notice that civil rights here are not denied by forcible treatment, but by mental illness itself, much like the way Davoli (2002) argued. Further, such statements frame arguably systemic problems like patient homelessness or incarceration in terms of impaired insight, akin to Lamb's (2009) editorial.

Other controversial elements of such legislation include the potential release of formerly protected patient medical information to caregivers, and an expansion of Medicaid funding for larger institutional settings. Where proponents see the latter as a crucial way to scale care, critics see the same action as a return to the evils of asylum

warehousing. Patient activists and civil libertarians have not let these proposals for outpatient commitment, threats to privacy, and hospital expansion go by without a media fight. As mental health rights activist Baker (2016) wrote on the progressive website *truth-out.org*,

... the Murphy Bill lets politicians falsely claim progress against gun violence while stigmatizing people with mental illness, undermining civil liberties, and diverting attention away from institutionalized racism and structural poverty. Actually, it does nothing to increase access to vital resources or address the pandemic of police violence against people with mental illness.

Such rhetoric is evidence that the radical mental health community still has alternative explanations for the crises of the American mental health system. Yet given the bipartisan support for the Murphy Bill and its passage as part of the larger “21st Century Cures Act,” such legislation has gained the upper hand. Although it is too early to evaluate implementation, and the authors of Maryland HB 767 are regrouping after defeat, these bills demonstrate the role of the impaired insight logic in struggles over mental health policy and patient rights.

Finally, to understand the potential impact of AOT expansion it is useful to look at evidence from New York State, one of the few fully implemented and researched AOT programs. Local governments have experimented with various forms of outpatient commitment since the 1980s, and AOT is on the books in 45 states, but only 20 states have documented evidence of actually operating programs (Meldrum et al. 2016). Drawing on observations of outpatient commitment procedure in New York, Player (2015) finds that the two most frequently cited and effective justifications for commitment are non-compliance and poor insight, respectively. Furthermore, it is only by becoming insightful that a person may have a chance of release. Player (2015, p. 109) quotes one attorney,

Really, practically, the only way you can expect to win a hearing is if your client is going to get up and testify with insight that they know they have a mental illness and they know they need the medication.

Thus, for those classified as lacking insight, the catch 22 mediates literal freedom from state monitoring. Subjected to surveillance and control in the community, AOT is a space between confinement and release, with insight linking the divergent logics of psychiatry and the law.

## Discussion and conclusion

Jurists, medical professionals, patients, family members, and policymakers have repeatedly addressed a seemingly intractable dilemma since the nineteenth century introduction of psychiatric expertise into courtrooms: how can mad people be judged legally when psychiatry and the law have divergent accounts of human action and responsibility? Each attempt to resolve this dilemma has generated new practical problems as well as path dependency in the kinds of future solutions available. The

creation of the asylum responded to the problem of unmoored madness during early capitalist development with a paternalistic vision of patients as outside of freedom, but it also led to new problems of abuse, warehousing, and an expensive welfare apparatus (see Scull 1977). Deinstitutionalization addressed the fiscal crisis of the Western welfare state and offered civil liberties to the confined, but it also contributed to wide-scale patient poverty and trans-institutionalization into the penal system (see Scull 1989). What could create a durable link between psychiatry and the law after the civil libertarian turn, and what system could replace the brutal legacies of both the asylum and its absence?

My claim is that impaired insight emerged as a way to make sense of and address new practical problems after deinstitutionalization disrupted longstanding management practices. In a situation where putatively mad people were free to make their own choices, the key site of governance became *compliance* with medication. By framing the persistent crises of American mental health care as a failure of governance *through* mad peoples' freedom, the impaired insight category became a justification for paternalistic governance *around* it. The concept *translated* disparate practical problems of actors across social space—doctors and patients in the clinic, scientists in the lab, families in the home, police and outreach workers on the street, lawyers and defendants in court, prison wardens managing overflow—into a common vocabulary that could link psychiatric and legal logics. It further *coordinated* the interests of such varied actors across scales into both everyday solutions and commitment law reform. Drawing on the sociology of science, I have shown where such objects as psychological scales, brain scans, and legal code facilitated new forms of human perception and agency.

Accompanying the discourse of impaired insight is a proposed structural intervention, the expansion of outpatient commitment orders, which might split the difference between the coercion of the asylum and the “freedom” of deinstitutionalization. Thus one answer to the overarching question of how liberal societies can govern those at the border of legal capacity, and with what justification, is outpatient commitment and the discourse of impaired insight. Rather than attempt to resolve the liberal dilemma normatively or comment on the scientificity of impaired insight for psychosis, I have sought to historicize these debates and identify the logics framing both moral and scientific positions. Insight discourse remains controversial in both legal and psychiatric circles, but it need not work in either fully, because it exists between the two. Within specific spaces that see the potential for a clash of psychiatric and legal institutional logics—insanity pleas, commitment hearings, prison housing, disability evaluation—impaired insight is an attempt to link them.

As a caveat, it is important to note that this story is a particularly American one. Recall that US thinkers like Szasz (1964) and Morse (1982) advocated a radical libertarianism that saw criminal trial as fairer than hospitalization, and in some sense the American criminalization and social abandonment of mad people resembles this model. Consider in contrast the mental health policy of other liberal states like the United Kingdom, France, or Australia, which have guaranteed health coverage, more robust welfare states, and relatively restrained penal apparatuses. These countries have also struggled with the aftermath of deinstitutionalization, yet the crises have been less drastic. Beyond the stronger welfare systems, this may be due to their relative paternalism: each has provisions for coercive care on a “need for treatment” basis, in contrast to the almost exclusive focus of the United States on “danger to self or others”

(Gourevitch et al. 2013). There are further differences in the degree to which family advocates have made inroads in research and law. Yet if this makes the dynamics of the United States less generalizable to liberal polities at large, it also makes it an extreme case that reveals the liberal dilemma with additional clarity. Thinking beyond the case, this article makes three contributions.

First, reflecting on the history of deinstitutionalization allows us to pose a question Foucault might have asked had he lived longer: If the discovery and confinement of unreason helped usher in the Enlightenment era of Reason (Foucault 1965), what is the significance of a legal system that attempts to project freedom and reason onto unreasonable subjects?<sup>5</sup> Are civil libertarian laws simply another illustration of the boundary that the practitioners of Reason use to mark their jurisdiction? Or is it the hubris of Reason at this stage in its development to presume itself universal, making further and further beachheads into the domain of unreason? Rather than read some unfolding of deep tendencies in the Western world, I think we are better off seeing this as a structural, cultural, and technological accident. A long-term settlement between reason and unreason was destabilized by a fiscal crisis, civil libertarian logics, and an overly optimistic faith in antipsychotics. Current attempts to resolve this with impaired insight and outpatient commitment are not the work of reason and unreason personified, but pragmatic responses to everyday problems in a contradictory system.

Second, the case of mad people's insight is a key for understanding the broader problem of liberal governance, for it shows a lacuna in Rose's (1999) influential formulation. With a model drawn from workfare projects to make the "welfare-dependent" poor into self-governing economic actors, Rose misses the subtle impact of mental illness categorization. As Davis (2012) notes, occupational programs for people with schizophrenia draw on similar discourses of self-sufficiency as workfare, but the goals of work are explicitly *therapeutic* rather than ethical. By writing from the "we" of society and neoliberal subjects at large, Rose's theory of government neglects a major part of the Foucaultian project: how modern institutions use the pathological to define the normal. It is precisely in concepts like impaired insight that the details of freedom, selfhood, and responsibility are reworked. People deploy the logic to inculpate or exculpate in court, responsabilize or ir-responsibilize, and grant or repeal disability disbursement. Although some mental health law appears to treat mad people as full legal subjects, the boundary between sanity and insanity continues to mediate participation in liberalism. Any theory of "neoliberal governmentality" must investigate these shifting boundaries to account for the actual practices of freedom and order.

Third is a methodological point. This article brings together Haydu's (1998) "reiterated problem solving," Foucaultian "problematization," and a pragmatist focus on problems of everyday life. If Haydu helps us understand how perennial, often structural problems unfold across time by tying periodization to solution attempts, the scale is poorly suited for emergent ways of thinking or everyday life. Foucaultians offer tools for analyzing emergent objects but do not deal well with reiterated problems across time. By privileging epochal, epistemic breaks, such an approach can blind scholars to a kind of historical continuity through repeated dilemmas (for an exception see Valverde 1998 on "repetition.") Finally, a pragmatic or even ethnographic lens on everyday problems (e.g. Tavorly and Timmermans 2014), less frequently used in

<sup>5</sup> I thank Aaron Panofsky for help posing and phrasing this question.



structural analysis, keeps the investigation grounded in the action of life. In the project at hand, the practical problems of treatment non-compliance, the conceptual problematization of the insight/compliance nexus, and the overarching reiterated problem of governing psychiatric patients as legal subjects each oriented me to different analytic avenues. Although theorists (e.g., Koopman 2011, Rabinow 2011) have noted this potential meeting point between Foucaultian and pragmatist inquiry, they have yet to articulate a guide to empirical research. I hope that my use of these three approaches to “problems” can offer future analysts a useful way to do research across time scales and modes of action.

As a final note, we should not expect the current wave of mental health reform to settle anything. Should the science of impaired insight and the structural expansion of outpatient commitment emerge victorious, this will soon generate its own practical dilemmas. As the quotation from the activist Baker (2016) suggests, there are powerful alternative frames for explaining the crises of American mental health care. The impaired insight concept may paper over the dilemma of reconciling psychiatric and legal logics, but it does not resolve it. Where the pendulum between confinement and freedom will swing next is an open empirical question, but any solution is unlikely to satisfy a broad array of stakeholders. So long as liberal states aim to control mad people without criminalizing them, or empower them without providing substantive support, there will be tension regarding loopholes that bar some people from full legal status. If not an actual prediction, that is the lesson I draw from this reiterated history.

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## References

- Abbott, A. (1988). *The system of professions: An essay on the division of expert labor*. Chicago: University of Chicago Press.
- Amador, X. (2000). *I am not sick, I don't need help!: How to help someone with mental illness accept treatment*. New York: Vida Press.
- Amador, X. (2013). Letter: Condition Obscures Mental Illness. *Hartford Courant*.
- Amador, X., & Strauss, D. (1990). *The scale to assess unawareness of mental disorder (SUMD)*. New York: Columbia University and New York State Psychiatric Institute.
- Appelbaum, P. S. (1984). Is the need for treatment constitutionally acceptable as a basis for civil commitment? *The Journal of Law, Medicine & Ethics*, 12(4), 144–149.
- Appelbaum, P. S., & Gutheil, T. (1979). ‘Rotting with their rights on’: Constitutional theory and clinical reality in drug refusal by psychiatric patients. *The Bulletin of the American Academy of Psychiatry and the Law*, 7(3), 306–315.
- Armstrong, D. (2009). Origins of the problem of health-related Behaviours: A genealogical study. *Social Studies of Science*, 39, 909–926.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders, fourth edition: DSM-IV-TR®. American Psychiatric Association Publishing.

- Baker, S. (2016). *Coercive Mental Health Legislation Threatens Rights of People with Disabilities*. <http://www.truth-out.org/opinion/item/36933-coercive-mental-health-legislation-threatens-rights-of-people-with-disabilities>. Accessed 10 Sept 2016.
- Bedford, N., Surguladze, S., Giampietro, V., Brammer, M., & David, A. S. (2012). Self-evaluation in schizophrenia: an fMRI study with implications for the understanding of insight. *BMC Psychiatry*, *12*, 106.
- Bennion, E., 2013. Right to remain psychotic-a new standard for involuntary treatment in light of current science, *A. Loyola of Los Angeles Law Review.*, *47*, p. 251.
- Berrios, G. E. (1994). Delusions: Selected historical and clinical aspects. In E. Critchley (Ed.), *The Neurological Boundaries of Reality* (pp. 251–268) Farrand Press.
- Berrios, G. E. (1996). *The history of mental symptoms: Descriptive psychopathology since the nineteenth century*. Cambridge: Cambridge University Press.
- Bipolar: Crazy Mermaid's Blog. (2013). *Anosognosia Rears Its Ugly Head (Again)*. <http://crazymer1.wordpress.com/2012/10/17/anosognosia-rears-its-ugly-head-again/>. Accessed 24 Dec 2014.
- Blumenthal, S. L. (2006). The deviance of the will: Policing the bounds of testamentary freedom in nineteenth-century America. *Harvard Law Review*, *119*, 959–1034.
- Bowker, G. C., & Star, S. L. (1999). *Sorting things out: Classification and its consequences*. Cambridge: MIT Press.
- Brodwin, P. (2012). *Everyday ethics: Voices from the front line of community psychiatry*. Berkeley: University of California Press.
- Callon, M. (1986). Some elements of a sociology of translation: Domestication of the scallops and the fishermen of St. Brieuc Bay. In *Technoscience. The Politics of Intervention*, Redigert Av Kristin Asdal, Ingunn Brenna, Og Ingunn Moser, pp. 57–78.
- Caplan, L. (1984.) The insanity defense and the trial of John W. Hinckley, Jr. Boston: DR Godine.
- Chase, A. (2000). Harvard and the making of the Unabomber. *Atlantic Monthly*, *285*(6), 41–65.
- Collins v. Strue*, No. 11-3060 (W.D. Ark. Sept. 5, 2012).
- David, A. S. (1990). Insight and psychosis. *The British Journal of Psychiatry*, *156*(6), 798–808.
- Davidson, L. (2013). Letter: Mental illness fallacies counterproductive. *Hartford Courant*.
- Davis, E. A. (2012). *Bad souls: Madness and responsibility in modern Greece*. Durham: Duke University Press.
- Davoli, J. (2002). Still stuck in the Cuckoo's Nest: Why do courts continue to rely on antiquated mental illness research. *Tennessee law Review*, *69*, 987.
- Dekker, T. (1604/2010). *The Dramatic Works of Thomas Dekker: Vol 2*. Whitefish: Kessinger Publishing.
- Dobransky, K. (2009). The good, the bad, and the severely mentally ill: Official and informal labels as organizational resources in community mental health services. *Social Science & Medicine*, *69*(5), 722–728.
- Dumit, J. (2004). *Picturing personhood: Brain scans and biomedical identity*. Princeton: Princeton University Press.
- Eigen, J. P. (1995). *Witnessing insanity: Madness and mad-doctors in the English court*. New Haven: Yale University Press.
- Epstein, S. (1996). *Impure science: AIDS, activism, and the politics of knowledge*. Berkeley: University of California Press.
- Estroff, S. (1981). *Making it crazy: An ethnography of psychiatric clients in an American community*. Berkeley: University of California Press.
- Eyal, G. (2013). For a sociology of expertise: The social origins of the autism epidemic. *American Journal of Sociology*, *118*(4), 863–907.
- Foucault, M. 1965. *Madness and Civilization* (R. Howard, Trans.). New York: Pantheon, Abridged Edition.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972–1977*. New York: Pantheon Books.
- Foucault, M. (2003). *Abnormal: Lectures at the Collège de France, 1974–1975*. London: Macmillan.
- Geisen, L., & Feuer, E. (1984). Case report: The treatment-resistant patient and the need to stay crazy. *Psychiatric Quarterly*, *56*(1), 75–82.
- Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Doubleday.
- Goldstein, J. 1989 (2001). *Console and and classify: The French psychiatric profession in the nineteenth century*. Chicago: University of Chicago Press.
- Gourevitch, R., Brichant-Petitjean, C., Crocq, M. A., & Petitjean, F. (2013). Law & psychiatry: The evolution of laws regulating psychiatric commitment in France. *Psychiatric Services*, *64*, 609–612.
- Haydu, J. (1998). Making use of the past: Time periods as cases to compare and as sequences of problem solving 1. *American Journal of Sociology*, *104*(2), 339–371.
- Heller, J. (1961). *Catch-22: A novel*. New York: Simon and Schuster.
- Helping Families in Mental Health Crisis Act (2013). H.R. 3717. 113th Congress.
- Hindess, B. (1993). Liberalism, socialism and democracy: Variations on a governmental theme. *Economy and Society*, *22*(3), 300–313.

- Hinterbuchner, L. P. (1974). Aphasia. *Bulletin of the New York Academy of Medicine*, 50(5), 589–601.
- Hursey v. Taglia, No. 1: 11-CV-388 (W.D. Mich. Sept. 10, 2012).
- Johnson, S., & Orrell, M. (1996). Insight, psychosis and ethnicity: A case-note study. *Psychological Medicine*, 26(05), 1081–1084.
- Jones, N., & Brown, R. (2012). The absence of psychiatric C/S/X perspectives in academic discourse: Consequences and implications. *Disability Studies Quarterly*, 33(1), 6.
- Kelty, C., & Landecker, H. (2009). Ten thousand journal articles later: Ethnography of "the literature" in science. *Empiria. Revista de metodologia de Ciencias Sociales*, 18, 173–192.
- Keomany v. Comm'r of Human Services, No. A11-1800 (Minn. Ct. App. Apr. 16, 2012).
- Kirk, S., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. Piscataway: Transaction Publishers.
- Kirmayer, L., & Corin, E. (2004). Inside knowledge: Cultural constructions of insight in psychosis. In X. F. Amador & A. S. David (Eds.), *Insight and psychosis* (pp. 193–220). New York: Oxford University Press.
- Koopman, C. (2011). Genealogical pragmatism: How history matters for Foucault and Dewey. *Journal of the Philosophy of History*, 5(3), 533–561.
- Kraepelin, E. (1917). *Lectures on clinical psychiatry*. New York: William Wood.
- Kress, K. (2004). Why lack of insight should have a central place in mental health law. In X. Amador & A. David (Eds.), *Insight and psychosis* (p. 257). New York: Oxford University Press.
- Laing, R. (1967). *The politics of experience*. New York: Ballantine Books.
- Lakoff, A. (2005). *Pharmaceutical reason: Knowledge and value in global psychiatry*. Cambridge: Cambridge University Press.
- Lamb, H. (2009). Reversing criminalization. *American Journal of Psychiatry*, 166(1), 8–10. doi:10.1176/appi.ajp.2008.08101515.
- Lamb, H., & Weinberger, L. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of the American Academy of Psychiatry and the Law Online*, 33(4), 529–534.
- Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Cambridge: Harvard University Press.
- Levine, J., Toder, D., Geller, V., Kraus, M., Gauchman, T., Puterman, M., & Grisaru, N. (2012). Beneficial effects of caloric vestibular stimulation on denial of illness and manic delusions in schizoaffective disorder: A case report. *Brain Stimulation*, 5(3), 267–273.
- Lewis, A. (1934). The psychopathology of insight. *British Journal of Medical Psychology*, 14(4), 332–348.
- Luhrmann, T. (2000). *Of two minds: The growing disorder in American psychiatry*. New York: Alfred A. Knopf.
- Maryland House Bill 767 (2014). Public Health-Mental Hygiene Law-Assisted Outpatient Treatment.
- Mayer-Gross, W. (1920). Über die Stellungnahme auf abgelaufenen akuten Psychose. *Zeitschrift Gesamte Neurologie Psychiatrie*, 60, 160–212.
- McEvoy, J., Aland, J., Wilson, W., Guy, W., & Hawkins, L. (1981). Measuring chronic schizophrenic patients' attitudes toward their illness and treatment. *Psychiatric Services*, 32(12), 856–858.
- McEvoy, J., Apperson, L., Appelbaum, P., Ortlip, P., Brecosky, J., Hammill, K., Geller, J., & Roth, L. (1989). Insight in schizophrenia. Its relationship to acute psychopathology. *The Journal of Nervous and Mental Disease*, 177(1), 43–47.
- McGlashan, T., & Carpenter, W. (1976). Postpsychotic depression in schizophrenia. *Archives of General Psychiatry*, 33(2), 231.
- Meldrum, M. L., Kelly, E. L., Calderon, R., Brekke, J. S., & Braslow, J. T. (2016). Implementation status of assisted outpatient treatment programs: A National Survey. *Psychiatric Services*, 67(6), 630–635.
- Morse, S. (1982). A preference for liberty: The case against involuntary commitment of the mentally disordered. *California Law Review*, 70(1), 54–106.
- Munetz, M. R., Galon, P. A., & Frese, F. J. (2003). The ethics of mandatory community treatment. *Journal of the American Academy of Psychiatry and the Law Online*, 31(2), 173–183.
- Murphy, M. (2006). *Sick building syndrome and the problem of uncertainty: Environmental politics, Technoscience, and women workers*. Durham: Duke University Press.
- Murphy, T. (2014). Congress in denial on mental illness. Clip from C-Span. <https://murphy.house.gov/common/popup/popup.cfm?action=item.print&itemID=2728>. Accessed 10 Sept 2016.
- Novas, C., & Rose, N. (2000). Genetic risk and the birth of the somatic individual. *Economy and Society*, 29(4), 485–513.
- Rabinow, P. (2011). Dewey and Foucault: What's the problem? *Foucault Studies*, 11, 11–19.
- Rhodes, L. (2004). *Total confinement: Madness and reason in the maximum security prison*. Berkeley: University of California Press.
- Rose, N. (1999). *Powers of freedom: Reframing political thought*. Cambridge: Cambridge University Press.

- Rose, N. (2000). The biology of culpability: Pathological identity and crime control in a biological culture. *Theoretical Criminology*, 4(1), 5–34.
- Rosenberg, C. (1968). *The trial of the assassin Guitreau: Psychiatry and the law in the gilded age*. Chicago: University of Chicago Press.
- Rothman, S., Raveis, V., Friedman, A., & Rothman, D. (2011). Health advocacy organizations and the pharmaceutical industry: An analysis of disclosure practices. *American Journal of Public Health*, 101(4), 602.
- Saks, E.R. (2012). Competency to refuse medication: Revisiting the role of denial of mental illness in capacity determinations. *S. Cal. Rev. Law & Social Justice*, 22, p. 167.
- Scheff, T. (1966). *Being mentally ill: A sociological theory*. Chicago: Aldine.
- Scull, A. (1977). *Decarceration: Community treatment and the deviant—A radical view*. Upper Saddle River: Prentice-Hall.
- Scull, A. (1989). *Social order/mental disorder: Anglo-American psychiatry in historical perspective*. Berkeley: University of California Press.
- Shostak, S., Conrad, P., & Horvitz, A. (2008). Sequencing and Its Consequences: Path Dependence and the Relationships between Genetics and Medicalization. *American Journal of Sociology*, 114, S287–S316.
- Skålevåg, S. A. (2006). The matter of forensic psychiatry: A historical enquiry. *Medical History*, 50(01), 49–68.
- Slobogin, C. (1996). "Appreciation" as a measure of competency: Some thoughts about the MacArthur Group's approach. *Psychology, Public Policy, and Law*, 2(1), 18.
- Smith, D. (1978). K is mentally ill' the anatomy of a factual account. *Sociology*, 12(1), 23–53.
- Smith, R. (1981). *Trial by medicine: Insanity and responsibility in Victorian trials*. Edinburgh: Edinburgh University Press.
- Star, S. L., & Griesemer, J. (1989). Institutional ecology, 'translations' and boundary objects: Amateurs and professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science*, 19(3), 387–420.
- Struck v. Cook County Public Guardian*, No. 1-07-1865 (Ill. App. Ct. Dec. 17, 2008).
- Szasz, T. S. (1964). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Harper & Row.
- Tavory, I., & Timmermans, S. (2014). *Abductive analysis: Theorizing qualitative research*. Chicago: University of Chicago Press.
- Tighe, J. (2005). "What's in a name?": A brief foray into the history of insanity in England and the United States. *The Journal of the American Academy of Psychiatry and the Law*, 33(2), 252.
- Timmermans, S., & Berg, M. (1997). Standardization in action: Achieving local universality through medical protocols. *Social Studies of Science*, 27(2), 273–305.
- Torrey, F., & Kress, K. J. (2004). The new neurobiology of severe psychiatric disorders and its implications for laws governing involuntary commitment and treatment. *Uof Iowa Legal Studies Research Paper*, (04-04).
- Tranulis, C. S., Freudenreich, O., & Park, L. (2009). Narrative insight: Rethinking insight in psychosis. *International Journal of Culture and Mental Health*, 2(1), 16–28.
- Treffert, D. A. (1973). Dying with their rights on. *The American Journal of Psychiatry*, 130(9), 1041.
- Valverde, M. (1998). *Diseases of the will: Alcohol and the dilemmas of freedom*. Cambridge: Cambridge University Press.
- Van Putten, T. (1974). Why do schizophrenic patients refuse to take their drugs? *Archives of General Psychiatry*, 31(1), 67–72.
- Van Putten, T., Crumpton, E., & Yale, C. (1976). Drug refusal in schizophrenia and the wish to be crazy. *Archives of General Psychiatry*, 33(12), 1443–1446.
- Walker, S. (1999). *In defense of American liberties: A history of the ACLU*. Carbondale: SIU Press.
- Whitaker, R. (2011). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Broadway Books.
- Wing, J., Cooper, J., & Sartorius, N. (1974). *Measurement and classification of psychiatric symptoms: an instruction manual for the PSE and Catego Program*. Cambridge: Cambridge University Press.
- Young, D. A., Davila, R., & Scher, H. (1993). Unawareness of illness and neuropsychological performance in chronic schizophrenia. *Schizophrenia Research*, 10(2), 117–124.

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