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THE SIMULACRUM OF MENTAL ILLNESS, THE DSM, AND MADNESS

Kathryn Burrows, Ph.D.
(Seattle, WA, USA)

Correspondence should be addressed to: kateburrows1975@gmail.com

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Abstract

This paper examines how modern psychiatric diagnosis may have created an artificial version of mental illness that has replaced genuine human experiences of psychological distress. Drawing on philosopher Jean Baudrillard's concept of "simulacra"—copies or representations that no longer refer to any original reality—I argue that psychiatric classification systems like the Diagnostic and Statistical Manual (DSM) don't simply describe mental conditions but actively create them through technical language and categories. Rather than reflecting the lived reality of people experiencing psychological distress (what I call "madness"), the DSM has generated what Baudrillard would term a "hyperreality"—a constructed world of psychiatric categories that has become more real and influential than the original human experiences it claims to represent. This system of classification wields enormous power to define what counts as normal versus abnormal, determining who can be involuntarily hospitalized, medicated, or subjected to other forms of psychiatric control.

The paper also incorporates Michel Foucault's analysis of how medical and scientific institutions exercise social control through surveillance and the authority to define illness. Together, these theoretical frameworks reveal how psychiatric knowledge may function less as objective science and more as a system of power that manages social difference by labeling it as pathology.

I argue that this "simulacrum of mental illness" provides justification for forcibly confining and treating people diagnosed with psychiatric conditions, even when they have committed no crimes. While acknowledging that psychological suffering is real and requires compassionate response, I question whether our current diagnostic frameworks truly serve those experiencing distress or primarily function to maintain social order through medical authority.

The goal is not to dismiss the reality of psychological pain, but to create space for examining how psychiatric knowledge constructs the very phenomena it claims to describe, and to consider alternative approaches to mental difference that might better honor human complexity while remaining alert to how power operates through supposedly neutral medical categories.

Keywords: Mental illness; simulacra; simulation; psychiatry; social control; power; surveillance

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> "Abstraction today is no longer that of the map, the double, the mirror, or the concept. Simulation is no longer that of a territory, a referential being or a substance. It is the generation by models of a real without origin or reality: a hyperreal [...] it is the map that precedes the territory — precession of simulacra — it is the map that engenders the territory [...]"
>
> Jean Baudrillard (Baudrillard, *Jean Baudrillard: Selected Writings*)

INTRODUCTION

Jean Baudrillard's theory of simulation and simulacra provides a framework for understanding how representations can become detached from—and eventually replace—the realities they originally depicted. Simulation refers to the process by which copies or models come to stand in for original phenomena, while a simulacrum is a copy that no longer has any meaningful relationship to an original reality it purports to represent. In Baudrillard's famous formulation, we reach a point where "the map precedes the territory"—meaning our representations and categories shape and create reality rather than simply reflecting it (Baudrillard, *Jean Baudrillard: Selected Writings*). Baudrillard outlined four stages of this process: first, representations reflect reality; second, they mask and distort reality; third, they mask the absence of reality; and finally, they become pure simulacra bearing no relation to any underlying truth. While Baudrillard's ideas about simulations are typically applied to media, consumer culture, and physical objects, the concept can be extended to any human-created or social phenomenon, including systems of knowledge and classification. Social phenomena, like objects, are constructed by human beings and can be transformed or entirely replaced through the process of simulation—where the artificial categories and representations we create to understand experience eventually supersede the original experiences themselves.

Contemporary clinical practice in psychiatry has evolved significantly in recent decades, with the rise of trauma-informed care, recovery-oriented approaches, and increased emphasis on patient autonomy. Yet despite these progressive shifts, critical examination of the underlying epistemological foundations of psychiatric diagnosis remains essential. Baudrillard's theory of simulacra offers a particularly powerful framework for this analysis, revealing how diagnostic categories may function as self-referential signs increasingly detached from the phenomena they purport to describe. Today's mental health landscape features a dominant biomedical model that continually expands its taxonomic reach, creating what Baudrillard would term a "hyperreality"—a model that precedes and determines our understanding of psychological distress rather than reflecting it.

This hyperreal system of psychiatric classification does not operate in isolation from power structures, as Michel Foucault's analyses help us understand. Foucault examined how modern institutions exercise control not through overt force but through subtle mechanisms of surveillance, normalization, and the production of knowledge that defines what counts as normal or pathological. His concept of biopower—the management of bodies and populations through medical and scientific authority—reveals how psychiatric institutions shape behavior by creating categories of illness and wellness that people internalize and police in themselves. Foucault's famous panopticon metaphor illustrates how the mere possibility of being observed can induce self-regulation, making external control unnecessary. While psychiatric institutions may appear less overtly controlling than the asylums Foucault critiqued, subtler mechanisms of surveillance and compliance have emerged through community treatment orders, digital health monitoring, and the medicalization of ever-wider ranges of human experience. The intersection of Baudrillardian simulation and Foucauldian power dynamics creates a particularly fertile ground for examining how psychiatric knowledge constructs the very phenomena it claims to merely describe. Together, these theoretical perspectives allow us to question whether contemporary psychiatry maintains any meaningful connection to the lived realities it purports to represent, or whether it has become a self-perpetuating system of control operating through increasingly sophisticated simulations of "mental illness. "This philosophical exploration, while necessarily speculative, carries significant practical implications. The value lies not in conclusively proving that mental illness concepts are simulacra, but in disrupting the taken-for-granted nature of diagnostic frameworks that powerfully shape individual lives and institutional responses. By examining the potential simulation of psychiatric categories and their relationship to social control, we open critical space for alternative conceptualizations of psychological distress that might better honor the complexity of human experience while remaining alert to the operation of power in supposedly neutral medical knowledge.

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In this paper, I will explore the Diagnostic and Statistical Manual of Mental Disorders (DSM)—the authoritative classification system used by mental health professionals to diagnose psychiatric conditions—and the medicolegal concept of 'mental illness' as a simulacrum that precedes any direct human experience that may be classified as such. The DSM, currently in its fifth edition (DSM-5), published by the American Psychiatric Association in 2013, serves multiple functions: it provides standardized criteria for identifying mental disorders, facilitates communication between clinicians, and determines eligibility for insurance coverage and disability benefits.[59] The manual divides psychological distress into hundreds of discrete diagnostic categories, each defined by specific clusters of symptoms, behaviors, and experiences that must be present for a certain duration and severity. However, viewing the DSM through Baudrillard's theoretical lens, I argue that this classification system functions as more than a neutral diagnostic tool. As a simulacrum, the categories set out in the DSM, and the logic that they embody, create mental illness from whole cloth—generating the very phenomena they claim merely to describe and organize.

The DSM functions as the foundational legal and medical framework that enables coercive psychiatric interventions by transforming subjective experiences into objective pathologies that justify the suspension of normal civil liberties. Mental health laws across jurisdictions explicitly reference DSM diagnostic criteria as prerequisites for involuntary commitment, creating a direct pathway from classification to coercion. When individuals receive diagnoses such as schizophrenia, bipolar disorder, or major depression, these labels become legal instruments that authorize psychiatrists to petition courts for involuntary hospitalization based on perceived "dangerousness" or "grave disability"—standards that are often interpreted subjectively but carry the weight of scientific authority because they are anchored in DSM categories. The diagnostic process itself becomes a form of judicial proceeding where the psychiatrist's clinical assessment, guided by DSM criteria, can override an individual's autonomous refusal of treatment. This medicalized coercion extends beyond hospitalization to forced medication, where court orders for psychotropic drugs are routinely granted based on the presumption that diagnosed individuals lack the capacity to make rational treatment decisions—a capacity that is paradoxically determined by the very same psychiatric system that benefits from override of consent. The DSM's expansion of diagnostic categories through concepts like "spectrum disorders" and "Not Otherwise Specified" classifications creates an ever-widening net that captures more individuals within coercive frameworks, while the manual's frequent revisions ensure that resistance to psychiatric authority can itself be pathologized and medicalized. Through this process, the DSM transforms what Foucault identified as disciplinary power into legal authority, allowing psychiatric knowledge to circumvent traditional protections against unlawful detention and forced medical procedures by reframing coercion as therapeutic intervention necessitated by objective medical conditions rather than subjective judgments about social deviance.

It is crucial to distinguish between voluntary and involuntary psychiatric admissions, as this analysis focuses specifically on the coercive mechanisms associated with enforced hospitalization rather than situations where individuals seek treatment voluntarily. While voluntary admissions involve patients who consent to hospitalization and retain the right to leave (though this right may be complicated by informal pressures or conversion to involuntary status), involuntary admissions represent a fundamental suspension of civil liberties where individuals are detained against their will based on psychiatric assessments of dangerousness or incapacity. The critique presented here concerns how the DSM's diagnostic categories serve as legal instruments that justify this coercive detention of non-criminal individuals.

In Baudrillard's theory, Simulacra refer to copies or representations that depict things that either had no original to begin with, or that no longer have an original. Simulacra are thus images or signs that mimic things that either never existed or no longer exist. The concept of simulacra is closely related to representation, but differs in key ways. Representation refers to using signs, images, or symbols to stand in for or depict some original object or idea. Representations have a relationship to some kind of originating truth or reality that they represent. Simulacra, on the other hand, have no tie to an original truth or reality. They mimic representations that either never had an original in the first place or whose original has long since disappeared. Simulacra thus achieve the appearance of representing some truth or reality, but in fact point to no underlying origin.

[59] The DSM does not provide guidelines for treatment.

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While I am certainly not arguing that mental distress, including such constellations of symptoms that the DSM identifies as composing schizophrenia or Bipolar Disorder, does not exist or never existed, I am arguing that the evolution of psychiatric classification systems like the DSM reflects a complex interplay between genuine attempts at scientific understanding and the extension of definitional control. While not necessarily designed with the explicit goal of 'capturing' individuals, the DSM's increasing taxonomic scope—particularly through concepts like spectrum disorders and 'Not Otherwise Specified' categories—has nonetheless expanded the boundaries of what constitutes mental illness. Contemporary clinical practice often employs the DSM in more nuanced ways than this critique might suggest; many practitioners use it primarily as a provisional guideline rather than diagnostic dogma, recognizing its limitations as a social construction nested within specific historical and cultural contexts. Yet despite this practical flexibility at the individual level, the institutional power of psychiatric classification systems remains formidable, creating frameworks through which experiences become medicalized, resources are allocated, and interventions justified. The simulacrum emerges not from individual clinical intentions but from the system's self-reinforcing logic, where the constructed categories increasingly reference themselves rather than any original phenomenon they purport to describe.

After putting forth the argument that mental illness and the DSM exist within a simulacrum, I will extend the discussion to signs and the signified, and how language and the primacy of scientific knowledge have created the simulacrum of mental illness, which has completely supplanted the original experience of madness. I conclude with a discussion of Foucault's ideas of social control, the medical gaze, and propose a marriage of these two theories. By combining these theoretical perspectives, I hope to show that the simulacrum of mental illness creates the conditions by which we allow the unwilling noncriminal incarceration of people diagnosed with mental illness. The simulacrum of mental illness provides a justification to forcibly manage the deviance of different bodies and minds through coercion and containment. Its value, and therefore its persistence and durability, and indeed, its growth and expansion into more areas of people's lives, lies in its ability to demand that we 'take action' against mental illness, in ourselves or in others, including the "compassionate use" (Trestman and Nagaraja) of force and involuntary confinement.

While mental illness encompasses a broad spectrum of conditions with varying impacts on functioning, the surveillance and control mechanisms discussed in this paper primarily target those diagnosed with severe and persistent mental illnesses (SPMI) such as schizophrenia, bipolar disorder with psychotic features, and other conditions involving psychosis and altered perceptions of reality, or other conditions the impair functioning such as depression and anxiety. These diagnostic categories have historically been subjected to the most intensive forms of institutional control, including involuntary hospitalization, chemical and physical restraint, and ongoing community monitoring. Symptoms involving psychosis—particularly hallucinations, delusions, and altered perceptions of reality—place individuals at heightened risk for coercive intervention because they are readily interpreted as evidence of impaired judgment and potential dangerousness. Behaviors categorized as indicating 'grave disability,' such as apparent inability to care for oneself or make 'rational' decisions, similarly trigger involuntary commitment mechanisms. The risk stems from how these subjective clinical assessments, anchored in DSM categories, acquire legal authority to override personal autonomy through seemingly objective medical determinations of incapacity. The simulacrum of mental illness reaches its most powerful expression in the management of these conditions, where perceived dangerousness and incompetence provide the justification for suspending normal civil liberties. While the DSM's taxonomic reach extends to milder conditions, the Foucauldian apparatus of surveillance and the Baudrillardian simulation of madness converge most forcefully at this end of the diagnostic spectrum.

This hyperreal system of psychiatric classification does not operate in isolation from power structures, as Foucault's analyses help us understand. While psychiatric institutions may appear less overtly controlling than the asylums Foucault critiqued, subtler mechanisms of surveillance and compliance have emerged through community treatment orders, digital health monitoring, and the medicalization of ever-wider ranges of human experience. The intersection of Baudrillardian simulation and Foucauldian power dynamics creates a particularly fertile ground for examining how psychiatric knowledge constructs the very phenomena it claims to merely describe. Together, these theoretical perspectives allow us to question whether contemporary psychiatry maintains any meaningful connection to the lived realities it purports to represent, or whether it has become a self-perpetuating system of control operating through increasingly sophisticated simulations of "mental illness."

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While this philosophical exploration examines mental illness as a simulacrum, it does not deny the very real psychological suffering that people experience. The existence of profound distress, altered perceptions, and debilitating emotional states cannot be dismissed—these experiences demand our ethical attention and compassionate response. What this analysis questions is not the reality of suffering itself, but rather how our classificatory systems frame, interpret, and ultimately transform that suffering through diagnostic categorization. The value of approaching mental illness through Baudrillard's lens lies not in conclusively proving that psychiatric categories are "merely" constructions, but in disrupting the taken-for-granted nature of our diagnostic frameworks. By recognizing the elements of simulation within psychiatric knowledge, we can create space for more nuanced approaches to psychological difference that acknowledge both the reality of distress and the power of classification systems to shape how that distress is understood and addressed. This theoretical perspective allows us to honor lived experiences of suffering while remaining critical of the institutional responses those experiences elicit.

A Quick Note on Terminology

Throughout this paper, I use the phrase 'mental illness' as synonymous with the DSM-created simulacrum, and the word 'mad' to represent the real experience of people. The term 'mad' refers to what I argue was the authentic, lived experience of psychological distress before it became organized and transformed by psychiatric classification systems—the raw human reality that existed before medical categories shaped how we understand and respond to psychological difference. According to Baudrillard's theory, this original experience has been entirely replaced by the simulation, making it impossible to access the pre-classification reality of madness.[60] I interchangeably use the phrases 'mental illness', 'the simulacrum', and the 'simulacrum of the DSM'.

By 'mental illness,' I refer to the overarching conceptual framework that encompasses the various diagnostic categories codified in the DSM. Rather than denoting a single condition, mental illness represents a constructed collection of "disorders"—distinct clusters of symptoms, behaviors, and experiences that psychiatric authorities have grouped and labeled as pathological.[61] While the DSM meticulously divides psychological distress into hundreds of discrete

[60] The distinction between "madness" and "mental illness" in this theoretical framework requires careful elaboration, as it forms the foundation of the simulacrum argument. "Madness," as used here, refers to a hypothetical pre-classificatory state of psychological difference and distress that existed before formal psychiatric nosology organized these experiences into discrete diagnostic categories. This includes what we might recognize today as experiences of altered perception, extreme emotional states, unconventional thought patterns, or behaviors that deviate from social norms—but understood without the mediating framework of medical pathology. However, this creates a fundamental epistemological problem: if Baudrillard's theory is correct, we cannot actually know what "madness" looks like in any contemporary context because the simulation has entirely replaced the original. We can only access historical accounts filtered through their own cultural lenses, such as descriptions of "melancholia," "lunacy," or spirit possession from pre-psychiatric eras. Contemporary attempts to reclaim "mad" identity through activism represent efforts to break through the simulacrum, but these efforts necessarily occur within and against the existing psychiatric framework, making them potentially complicit in the very system they seek to resist. This theoretical limitation is intentional rather than problematic: Baudrillard's fourth stage of simulation suggests that the original has been destroyed by its representation. Therefore, any attempt to define what "madness" currently looks like would actually be describing mental illness masquerading as madness. The value of maintaining this distinction lies not in recovering some authentic pre-psychiatric experience—which may be impossible—but in creating critical space to question whether our current diagnostic frameworks truly serve those experiencing psychological distress or primarily function to maintain social order through medical authority. The term "madness" thus serves as a placeholder for alternative ways of understanding psychological difference that are not immediately captured by pathologizing medical discourse.

[61] The case of neurodevelopmental conditions like ADHD and Autism Spectrum Disorder presents important complexities for this theoretical framework. These conditions differ significantly from the psychiatric diagnoses that form the primary focus of this analysis, as they involve documented neurological differences that can be observed across cultures and throughout history, even when not formally recognized or classified. The neurodiversity movement has successfully reclaimed many of these experiences as natural human variations rather than pathologies requiring cure, suggesting these conditions may occupy a different relationship to Baudrillard's simulacrum than traditional psychiatric categories. However, the DSM's approach to these conditions still demonstrates elements of the simulation process described in this paper. The expansion of autism diagnostic criteria to include "spectrum" designations, the proliferation of ADHD subtypes, and the medicalization of traits that might previously have been understood as personality differences or learning styles reflect the taxonomic expansion characteristic of psychiatric classification systems. The critical question is not whether neurological differences exist—they clearly do—but whether the specific ways these

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diagnostic entities, this theoretical umbrella term allows us to examine how the classificatory impulse itself—manifested through increasingly elaborate systems of diagnostic differentiation—may function as a simulacrum that precedes and shapes our understanding of human suffering, rather than simply describing pre-existing phenomena.
Throughout the paper, 'mental illness' is used as the sign for the signified 'mad', which, as I will explore shortly, according to Baudrillard, no longer exists.

THE TYRANNY OF CLASSIFICATION AND THE SIMULACRUM OF MENTAL ILLNESS

The concept of mental illness, as codified in classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), exists within a simulacrum detached from the basic reality of psychological distress and madness that once prevailed. This artificial simulation of mental disorders has been brought about through the forces of scientism and the act of categorizing inherently fluid and variable states of madness into neat diagnostic boxes. The classification project undertaken through nosologies like the DSM serves not to reflect any objective reality,[62] but rather to impose an ordered hyperreality that captures human struggles within its technical lexicon. The very act of trying to scientifically classify and categorize mental distress obscures the basic reality of madness that lies beneath people's experiences. As a result, the phenomenon of mental illness now circulates almost entirely within a closed system of psychiatry's creation, mapped onto people's lives through diagnosis but bearing little relation to genuine psychological reality. This results in the categorization of signs and symptoms with little regard for individuality. This modern regime of mental health, operating on the terrain of simulacra rather than authentic human experience, nevertheless carries very real consequences for those caught in its diagnostic web.

Research reveals significant challenges in the reliability and objectivity of psychiatric diagnosis that complicate claims about the scientific rigor of involuntary psychiatric admissions. Multiple studies demonstrate that psychiatric diagnoses show only "fair" agreement between standardized diagnostic interviews and clinical practice, with kappa values averaging around 0.41 (Neto et al.) This finding is particularly concerning given that even Spitzer and Frances, the directors of DSM-III and DSM-IV Task Force, admit that the desired reliability among the practicing clinicians has not been obtained (Aboraya). The reliability problem extends beyond psychiatry - studies show that agreement between medical specialists in other fields can be equally problematic, with pathologists examining the same tissue specimens achieving kappa values as low as 0.21 for needle biopsies (Pies).

The fundamental issue extends deeper than reliability concerns to questions about the validity of psychiatric diagnoses themselves. As Hyman (Hyman) argues, the DSM system prioritized interrater reliability at a time when "the scientific understanding of mental disorders was embryonic and could not yield valid disease definitions." This has led to what he describes as "reification" - treating diagnostic categories as if they were established medical entities when they remain largely descriptive constructs (Hyman). The problem is compounded by the fact that many disorders currently lack clear biological markers or "zones of rarity" that would support categorical distinctions from normal functioning (Kendell and Jablensky). Current legal frameworks for involuntary admission typically require the establishment of mental illness based on medical evaluation, yet the jurisprudence of the European Court on Human Rights clarified the conditions under which involuntary admissions can occur, requiring the establishment of a mental illness based on a medical evaluation, exceptionality and urgency, nature and gravity of the psychic disorder such as to justify the deprivation of liberty, measure proportional to the need for the safety of the patient and the community, and temporary limitation of the measure to the period of persistence of the illness (Saya et al.).

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differences are categorized, pathologized, and managed through institutional systems participate in the simulacrum of mental illness. Many individuals diagnosed with ADHD or autism report that diagnostic frameworks both validate their experiences and simultaneously constrain them within medical models that emphasize deficiency rather than difference. This suggests that even conditions with clear neurobiological correlates can become entangled in the broader apparatus of psychiatric control and normalization that this paper critiques, particularly when these diagnoses become grounds for educational segregation, pharmaceutical intervention, or other forms of institutional management that prioritize compliance over accommodation of neurodiversity.

[62] Although, to be fair, most of the diagnostic criteria are based on observable signs in the individual and describe signs and symptoms very clearly.

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Research on involuntary commitment decisions further illustrates how subjective factors influence what should be objective assessments. Feiring and Ugstad (Feiring and Ugstad) found that clinicians often equate serious mental disorder with loss of decision-making capacity without formal assessment, leading to a paternalistic approach where "trying voluntary solutions were pointless in most cases." The study revealed troubling practices, such as health enterprises being "recommended to apply involuntary mental health care to suicidal persons even when the disorder-criterion is not met," which participants acknowledged "contradict[ed] the intention of the law" (Feiring and Ugstad). These findings align with broader patterns documented in the international literature, where the various weights given to the patient's decision-making capacity in the various national legislations are reflected in the legality of pharmacological treatments in involuntarily hospitalized patients. In some countries (such as Italy), involuntary pharmacological treatments are automatically permitted for hospitalized patients, while others require a more articulated procedure to decide on treatment options (Saya et al.).

The decision-making process is further complicated by contextual factors that extend far beyond clinical considerations. Ethical and practical concerns are key reasons for the lack of RCTs comparing involuntary psychiatric hospitalization with outpatient care. Randomly assigning individuals who meet emergency or inpatient commitment criteria to outpatient follow-up care instead of usual care (e.g., involuntary hospitalization) carries substantial risks, including that study participants might harm themselves or others (Morris and Kleinman). This limitation in research design means that the evidence base for involuntary admission practices remains incomplete. Additionally, studies reveal that variations in the rates of involuntary admission (IA) reflect the influence of unexplained contextual variables that are typically too heterogeneous to be included in systematic reviews, with factors ranging from service-related factors, impactful events, seasonal and temporal factors, mental health legislation, staff factors, and public attitudes all influencing admission decisions (Aluh et al.).

The findings suggest that the decision-making process is influenced by multiple factors, such as setting, the clinician's tendency to detain patients, and the availability of detention beds (Engleman et al.) A large-scale study by McGarvey et al. (McGarvey et al.) examining 2,624 emergency mental health evaluations found that "unavailability of alternatives to hospitalization" was a significant predictor of involuntary commitment, with immediate medication evaluation, safe transportation, and temporary housing being key missing services. Importantly, even when the overall risk rating and all other patient and clinician variables were controlled, a patient had a significantly greater chance of being detained when detention beds were available (Engleman et al.). These patterns are consistent with research showing that few studies have specifically assessed the impact of the availability of alternative services, such as intensive community programs, on IA. In a study to determine the effect of the development of alternative services in French psychiatric sectors on involuntary inpatient care, the likelihood of a patient being forced into full-time hospitalization decreased by 12% for every 10% increase in the level of development of alternatives (Aluh et al.). This suggests that resource availability, rather than purely clinical considerations, can influence commitment decisions - a troubling finding that undermines claims of purely scientific decision-making in involuntary admissions.

While the entire concept of mental illness is examined here as a simulacrum, this does not negate the reality of experiences like paranoia, hallucinations, or profound mood disturbances that individuals undergo. These phenomena are only too real to those experiencing them, causing genuine suffering that demands ethical attention and practical response. The classification of such experiences into diagnostic categories can provide clinicians with useful frameworks for treatment selection and communication. However, when these categorization systems become rigid taxonomies that prioritize standardization over individual experience—treating the diagnosis rather than the person—they risk participating in the simulacrum that this paper critiques. The issue is not whether experiences like hearing voices exist, but rather how these experiences are constructed, interpreted, and managed within psychiatric frameworks that may have become increasingly self-referential and detached from the lived realities they purport to represent.

Viewing mental illness through Baudrillard's concept of simulacra offers profound implications for how we understand and respond to psychological distress. The stakes of this theoretical framework are significant. First, it demands we confront the possibility that our entire conceptual apparatus for understanding "mental illness" may have become untethered from the lived realities it purports to describe. If the DSM and its diagnostic categories have indeed reached

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Baudrillard's fourth stage of simulation—bearing "no relation to any reality whatever"—then our interventions may be addressing constructs of our own making rather than underlying human suffering.

This perspective doesn't deny that people experience profound psychological distress or that behaviors we label as "symptoms" cause real suffering. Rather, it questions whether our classificatory systems capture something fundamental about these experiences or whether they primarily serve to render them intelligible within existing power structures. The value of this approach lies in its potential to create critical distance from taken-for-granted medical frameworks, allowing us to interrogate how psychiatric knowledge constructs the very phenomena it claims merely to describe.

The simulacra framework also reveals what may be lost when madness becomes "mental illness"—namely, alternative ways of understanding psychological difference that don't immediately pathologize it. By recognizing the constructed nature of diagnostic categories, we can begin to imagine different relationships to psychological distress that might foster greater autonomy and dignity for those experiencing it. The stakes here involve nothing less than how society responds to human suffering and difference—whether through coercion justified by medical authority or through approaches that honor the complexity and diversity of human experience while remaining attentive to genuine distress.

While we cannot definitively prove that mental illness concepts are simulacra rather than accurate representations of reality, thinking through this possibility creates valuable space for questioning practices—like involuntary hospitalization and forced medication—that rely on the presumed objectivity of psychiatric diagnoses. What's ultimately at stake is how we balance care and control, compassion and coercion, in our responses to psychological difference.

Baudrillard makes the distinction between a simulacrum and the unreal. He writes, "Then the whole system becomes weightless; it is no longer anything but a gigantic simulacrum: not unreal, but a simulacrum [...]". The modern medicolegal mental illness structure is a simulacrum of what it used to be when it was real, before it became classified by Kraepelin in the late 1880's (Heckers and Kendler)- the fearsome asylums of the eighteenth and nineteenth centuries.[63] In the act of classifying mental conditions, a simulation was created. The real asylums, prior to the application of scientific classification, were mass warehouses for the mad, who were just beginning to give form and legitimacy to the new medical science of psychiatry (Scull). Prior to their warehousing and classification, the mad were simply that, mad. They lived variably in prisons, almshouses, or poorly cared for by family (Floyd). They were treated by medical doctors in the same way as other patients- mostly through purgatives and bloodletting (Floyd). At this point in time, and at the beginning of the asylum era, madness had yet to be classified and scientized. When these people began to become classified and labeled that the simulacrum began to be created.

Kraepelin's nosology, although not the first of its kind (Shorter), began the rather short march from real madness to the simulacrum of mental illness. Classification systems such as Kraepelin's and the DSM serve to capture madness and clean it up, make it acceptable, and safely lock it away. Baudrillard describes the process by which the real becomes a simulacra:

These would be the successive phases of the image:

> 1 It is the reflection of a basic reality.
> 2 It masks and perverts a basic reality.
> 3 It masks the absence of a basic reality.
> 4 It bears no relation to any reality whatever: it is its own pure simulacrum.

In this chronology, Baudrillard suggests that the first nosology, put forth by the ancient Greeks (Shorter), was not entirely a simulacra. It was, in fact, a reflection of basic reality. So, although that first system of categorization was a group of signs organized to describe a set of social conditions, those signs were still representative of reality. Theories and sets of signs such as the DSM function in four important ways. First, as "efficient storage devices for information collected over many years by many different people," second as "general descriptions of what a certain area of reality looks like,"

[63] The DSM Is fundamentally different from Kraepelin's nosology, primarily in its departure from Kraepelin's biological focus. However, the DSM has also been critiqued for its tendency towards overdiagnosis and a propensity toward scientifically questionable psychopharmacological approaches to treatment (Ghaemi).

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third, they form “a basis for generating expectations about what will happen if we go into a certain area […]” and lastly, they are the “basis for thinking about more complicated relationships” (Harvey). As a matter of ‘common sense,’ as part of our referential language, maps and theories (and classification systems like the DSM) embody the accumulated labor and thoughts of the past and serve as a reflection of basic reality (Smith). Therefore, those first attempts at classifying mental conditions did not fully obliterate reality- they were a group of signs that signified something that occurred in reality.

The concept of diagnostic classification preceding reality can be understood through Baudrillard's "precession of simulacra," where "the map precedes the territory." Rather than merely cataloging existing conditions, psychiatric nosology actively generates the phenomena it purportedly describes. Following Baudrillard's stages of simulation, early classifications like Kraepelin's initially reflected basic reality (first stage: "reflection of a basic reality"), before gradually perverting that reality (second stage: "masks and perverts a basic reality"), then masking its absence (third stage: "masks the absence of a basic reality"), and finally evolving into a pure simulacrum (fourth stage: "bears no relation to any reality whatever: it is its own pure simulacrum"). The DSM thus functions not as a passive observer but as an active constructor of meaning, determining what constitutes normal versus abnormal through categories that, despite their presentation as biological facts, remain "purely conventional and social" in nature. These diagnostic categories wield "immense definitional control" rather than simply documenting pre-existing symptoms. The frequent addition, modification, and deletion of diagnoses across DSM editions further demonstrates how these categories respond more to shifts in professional consensus and power dynamics than to stable biological realities. Consequently, it becomes impossible to access any original experience of madness behind the simulation, as the classification system has entirely replaced the phenomenon it claims to represent.

The medicolegal complex has imperialized the deviant body and mind, and the psychiatric empire controls everything within the simulacrum of mental illness, including peoples’ freedom from taking unwanted medications, being restrained, and being detained.[64] [65] Imperialist power such as this allows simulators like the DSM to make the real

[64] It is worth noting that strict legal measures and safeguards are in place in most countries that ensure that no individual can be deprived of their liberty for long periods or forced to take medication against their will. This can lead to real dangers for the individual (and sometimes society at large) when an individual experiencing the symptoms identified as schizophrenia cannot be supported in the community (lack of engagement with professionals, refusal to take anti-psychotics, etc.). Physical restraints in psychiatric settings are typically authorized under specific circumstances that vary by jurisdiction but commonly include: when a patient poses imminent danger to themselves or others (such as active suicide attempts or physical aggression toward staff or other patients); when a patient is severely agitated and at risk of self-injury during acute psychotic episodes; during involuntary medication administration when a patient actively resists; or when less restrictive interventions have failed to manage behaviors that could result in serious harm. Chemical restraints (forced sedating medications) may be administered when physical restraints alone are deemed insufficient to ensure safety. These interventions are generally supposed to be time-limited, regularly reviewed, and used only when alternative de-escalation techniques have proven ineffective, though the actual implementation of these safeguards varies significantly across institutions.

[65] While informed consent remains a foundational principle of medical ethics, it faces significant challenges within psychiatric contexts. Patients experiencing severe mental health crises may be deemed to lack "capacity" to make treatment decisions, legally justifying the suspension of their right to refuse treatment. However, this creates a circular logic: the very diagnosis that brings someone into the psychiatric system can be used to override their autonomy. The determination of "capacity" is often subjective and may be influenced by factors beyond clinical judgment, including patients' compliance with treatment recommendations or institutional convenience. Even when formal consent processes exist, they frequently occur within inherently coercive environments where patients understand that refusal may result in extended hospitalization, increased restrictions, or other punitive consequences. This transforms "consent" into what might be better described as "compliance under duress," where the appearance of voluntary agreement masks the underlying power imbalances that make genuine autonomous choice nearly impossible.

The legal standard of "harm to self or others" used to justify involuntary psychiatric intervention is notably vague and subject to considerable interpretive flexibility. "Harm to self" typically encompasses imminent suicide risk, severe self-injury, or inability to care for basic survival needs (sometimes termed "grave disability"), but the threshold for what constitutes "imminent" varies widely and often relies on clinical judgment rather than objective criteria. Some jurisdictions interpret this broadly to include behaviors like refusing medication, poor hygiene, or making decisions others deem irrational, effectively pathologizing non-conformity. "Harm to others" may include threats of violence, aggressive behavior, or perceived dangerousness, but research consistently

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coincide with the simulation model (Baudrillard, *Jean Baudrillard: Selected Writings*). The DSM has rather cleverly extended the simulation to this end by having categories for people who don't fit neatly into the simulator- these are the diagnostic concepts of "Not Otherwise Specified" (such as "Psychotic Disorder Not Otherwise Specified) and the concept of mental illness spectrums. In this way, real people are forced into the hyperreal condition of living with a mental illness. As an example of the scope creep of the mental illness simulacrum in motion, consider the diagnosis of panic disorder and its usefulness in controlling the deviant bodies of (mostly) women (Orr). The reach of the simulacrum is increasing- as of 2005, years before the DSM 5 was released, it was estimated that 46.4 percent of Americans would be diagnosed with a psychiatric disorder in their lifetime (Kessler et al.), and some research suggests that diagnoses such as depression have increased in recent decades (Blaszczak-Boxe). While one explanation for this increase in diagnosis is that 'symptoms' are really increasing with the times, another explanation is that the understanding and classification of these signs has changed in recent years, expanding the scope of the in habitants within the mental illness simulacrum.

In his essay, "Simulacra and Simulations", Baudrillard describes a "fake holdup." He challenges the reader to undertake a fake holdup- with a fake gun, a fake hostage, and a full intention to return any money gained. In his scenario, the fake robber would still get shot by a police officer's real gun, among other consequences. In this allegory, even though the fake robber is living in a simulacrum and the bank robbed is a simulation of a bank, there are real consequences to real people. Just like in this story, the consequences of mental illness in the simulacrum are quite real. For people in its grip, which threatens to soon invade almost every corner of society, there are real forced (or coerced) medications. Real 5-point-restraints. Real stigma and social isolation. And, real compelled hospitalization, sometimes lasting years (Testa and West).[66] Although mental illness under the reign of the DSM is a simulacrum, that does not mean that real things do not happen to real people and affect real lives.

The concept of informed consent further illustrates the paradoxes within the mental illness simulacrum. In standard medical practice, informed consent represents patient autonomy and requires voluntary agreement following adequate information disclosure and decisional capacity. However, within psychiatric contexts, this ethical cornerstone is periodically suspended through mechanisms like involuntary commitment and forced medication. The justification for these exceptions—that mental illness itself compromises the capacity for "rational" consent—creates a perfect circular logic: the system can override consent precisely because the patient has been classified within a system that questions their ability to consent. This circular reasoning exemplifies Baudrillard's notion of the closed system of simulacra that "bears no relation to any reality whatever." The concept of "capacity" itself becomes a simulacrum—a floating signifier that professionals can apply situationally to maintain control. Even when formal consent procedures exist, they often occur within power imbalances where patients face implicit threats (extended hospitalization, increased restrictions) for non-compliance, transforming "consent" into a simulation of autonomy rather than its exercise. This simulation maintains the appearance of ethical practice while simultaneously reinforcing the biomedical authority that Foucault identified as central to psychiatric control, creating what might be termed "simulated ethics"—ethical frameworks that masquerade as protective while primarily serving to legitimize existing power structures.

SIGNS, KNOWLEDGE, AND RESISTANCE

The classification of mental disorders through nosologies like the DSM does more than just categorize conditions - it actively constructs the very meaning of psychological distress (disguised as lists of symptoms). The language of

shows that people with mental illness are statistically more likely to be victims rather than perpetrators of violence, and that the correlation between mental illness and violence is weak except in cases involving active substance use. The predictive accuracy of violence risk assessments remains poor, with high rates of false positives leading to unnecessary detention of individuals who would not have harmed anyone. Furthermore, these determinations often occur during acute distress when individuals may appear more threatening than they actually are, and they may be influenced by factors such as race, class, and previous interactions with mental health systems. The subjectivity inherent in these assessments means that similar presentations may result in vastly different outcomes depending on the evaluating clinician, institutional policies, and local legal interpretations, raising questions about the consistency and fairness of applying such broad criteria to justify the suspension of fundamental civil liberties.

[66] It should be pointed out that, however, due to legal safeguards (at least in Western society), these are rare occurrences in relation to the number of individuals diagnosed with a mental disorder.

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psychiatry wields immense definitional power by determining which emotional states and behaviors are considered pathological versus normal. The authority to linguistically demarcate sanity from insanity grants the psychiatric profession extraordinary control over people's lives. Yet this bio-medical vocabulary rests on shaky scientific foundations, with diagnostic criteria shifting frequently due to opinion rather than evidence. Nevertheless, the primacy granted to scientific discourse in modern society allows psychiatric terminology to masquerade as objective fact. As a result, the real phenomenon of human madness has disappeared behind a simulated reality - a hyperreal fiction created by the technical jargon of the DSM. Even attempts to reclaim terms like “mad” or “psychotic” end up reinforcing rather than undermining the dominant medical paradigm. For true dissent to register, the linguistic hegemony underpinning the mental illness simulacrum must first be overturned. But overthrowing a knowledge system buttressed by scientific authority may prove the ultimate exercise in futility.

The authority to define and label behaviors, persons and things grants the greatest social control (Conrad). The definitions and distinctions that appear in the DSM can label people as good or bad, normal, or abnormal. This power is extraordinary, because these labels partially determine one’s life trajectory, and whether they are prone to be involuntarily confined within the mental illness simulacrum. The definitions within the DSM construct the meanings of mental difference, and have been created to fit competing ideologies and interests (Zerubavel). Because of the presumed biological nature of mental disorders, specialists and laypeople alike forget the purely conventional and social nature of DSM diagnoses, and instead attribute a profound natural power to these categories (Harkin), thereby strengthening and reinforcing the simulacrum. Bodies and minds are themselves a highly contested space, in which competing interests and figures of power vie for the right to define and sculpt that body and mind (Harkin). The concepts of normal/abnormal and mentally ill/mentally well exist as social constructs— people must define things as normal/abnormal— they are not “natural” states of being (Horwitz). Defining a body or mind as normal or abnormal does not occur in a vacuum, nor is it an automatic classification; instead, it is always in contrast to the normal that the abnormal is understood. As a sign system of classification, the DSM as a simulacrum has extraordinary power to overtake the people captured in its net,[67] because the labels applied are seen as “natural” and “biological,” so the power exerted over residents of the simulacrum, especially inpatients, is extreme and often absolute.

Research demonstrates that healthcare systems inadequately address the multiple determinants of mental health, focusing instead on narrow biomedical approaches that fail to recognize the complex social, economic, and environmental factors driving psychological distress. Alegría et al. document how mental health services consistently neglect "upstream" social determinants such as poverty, discrimination, housing instability, and food insecurity, despite substantial evidence linking these factors to mental health outcomes. The authors note that "poor and disadvantaged populations are most affected by mental disorders, and that cumulative stress and physical health serve as mechanisms through which the impacts of social determinants multiply across the lifespan" (Alegría et al. 2). This narrow focus on individual pathology rather than systemic factors interferes with truly beneficent care, as interventions that fail to address root causes—such as unemployment, inadequate housing, or community violence—may provide only temporary symptom relief while leaving patients vulnerable to ongoing distress. The research reveals that even when social determinants are recognized, mental health systems lack systematic approaches to address them, with most interventions remaining "considerably small in scale and utilized poor quality study design” (Alegría et al. 6). This gap between evidence about social determinants and actual practice represents a fundamental barrier to providing comprehensive, effective mental health care that truly serves patients' wellbeing.

Systems theories reveal how mental health care operates as a complex network of power relationships that systematically abuse authority through structural mechanisms rather than individual malice. Bracken and Thomas (2001) demonstrate how psychiatric systems maintain power through what they term the "modernist agenda," which privileges technical explanations over contextual understanding and enforces "coercive facets of psychiatry" through legal frameworks that grant psychiatrists extraordinary authority to detain and medicate patients. This systemic abuse operates through what the authors identify as three interconnected mechanisms: treating madness as purely internal

[67] True individuality is not taken into account in the DSM. It is up to the clinician who uses this tool to ensure individual meaning and capacity

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to individuals while ignoring social contexts, imposing technical frameworks that replace spiritual and cultural understandings, and institutionalizing coercion through mental health legislation that creates fundamental power imbalances between providers and patients. Speed extends this analysis by showing how these power structures manifest through different discourse systems—patient, consumer, and survivor—that shape how individuals can understand and articulate their experiences, with the "patient discourse" requiring "compliant passivity" and effectively silencing alternative ways of understanding psychological distress. The systemic nature of this abuse becomes evident in how these discourses function as "discursive resources" that limit agency: patients are constructed as "repositories of pathology," consumers face constrained choices within predetermined medical frameworks, and even survivor discourse can be co-opted by the system it seeks to resist (Speed 29–37). This represents a sophisticated form of institutional abuse that operates through seemingly benevolent therapeutic relationships while maintaining fundamental inequalities in power, knowledge, and the right to define reality.

Diagnoses are frequently changed, added, or deleted from the DSM, thereby changing who falls under the regime of the simulacrum. In the release of the DSM-5 in 2013, for example, 'hoarding disorder' was added and 'somatization disorder' was removed (American Psychiatric Association, *Diagnostic and Statistical Manual 5*). The newest revision of the volume, the DSM 5 TR, released in 2022, included the new diagnosis, 'prolonged grief disorder.' (Psychiatric News). For every release of a new edition, even a text revision such as the DSM 5 TR, a large team of experts (200 for the DSM 5 TR) reviews and presents change recommendations on every disorder in the manual (American Psychiatric Association, *DSM History*). This flexibility is advertised as demonstrating that the psychiatric community is constantly learning new science and refining their knowledge, relying on scientific discourse to justify their existence and their power over people with mental illness. However, the scientific foundation, although based on observations and the newest technology such as brain scans, on which psychiatric knowledge is built is tenuous at best, but these simulations are taken as natural fact and are seldom questioned (Moser). Despite the psychiatric establishment's claims that frequent revisions to the DSM represent scientific progress, the underlying research remains methodologically inconsistent and lacks the biological markers that would validate mental disorders as discrete medical entities; brain imaging studies often cited as evidence primarily show correlations rather than causation, and diagnostic boundaries continue to shift based more on professional consensus than on definitive empirical finding (Deacon). Science now plays the role of the arbiter of truth, which conceals the hegemony of the mental illness simulacrum, making it so no one will ever question the hyperreal fiction of the simulacrum that is standing in for madness (Moser).

While the discipline of psychiatry has become completely medicalized, ensuring its place among the professional safety of scientific doctrine, it has also become conjoined with judicial forces that can compel individuals to obey these pseudo-scientific signs, such as compulsory hospitalization (Erb). Although this fusion of law and medicine is certainly not new, it has gathered power in recent generations because of the scientization of psychiatric knowledge and the discipline now holds the enviable position as the purveyor of incontrovertible wisdom. Science, including psychiatric knowledge, has come to hold such a privileged position that it's teachings are seldom questioned, which reinforces the simulated signs of mental illness that has come to replace real madness (Moser).

The legal mechanisms governing forced psychiatric hospitalization vary significantly across jurisdictions, reflecting different cultural, ethical, and medical approaches to managing severe mental distress. In the United States, involuntary commitment typically requires meeting a "danger to self or others" standard, with specific criteria varying by state, though the 1975 O'Connor v. Donaldson Supreme Court ruling established that mental illness alone is insufficient justification for confinement (Testa and West). By contrast, the United Kingdom's Mental Health Act permits detention based on "health or safety" concerns or "protection of others," requiring approval from two doctors and an Approved Mental Health Professionals (Fistein et al.). German law maintains stricter criteria, typically requiring immediate danger and mandating judicial approval within 24 hours of emergency detention (Jacobsen). Japan's Mental Health and Welfare Act allows for particularly broad administrative commitment when a designated physician determines hospitalization "necessary," without requiring immediate dangerousness (Nakatani). The Nordic countries have moved toward more rights-protective frameworks, with Finland's Mental Health Act requiring both serious mental disorder and specific treatment need, while emphasizing the least restrictive alternative principle (Salize et al.). These international variations illuminate how the simulacrum of mental illness operates differently across cultural and legal contexts, yet universally

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maintains the power to suspend normal civil liberties through medicalized justifications that are frequently less stringent than those required to detain individuals in criminal proceedings (Large et al.).

The simulacrum is made up of signs and symbols that are intended to represent reality, although as Baudrillard explains, in the fourth step of simulations, the signs have come to completely replace the real experience (Baudrillard, *Jean Baudrillard: Selected Writings*). In writing about the simulacrum of mental illness, Moser questions, "Moreover, even if the reality of mental illness is difficult to dismiss, have signs of insanity substituted themselves for actual madness?" Here, he questions if the simulacrum has fully reached Baudrillard's fourth stage of simulations, although Foucault suggests an answer to that question by writing that the simulacrum which symbolically represents insanity has actually superseded real madness (Moser). In other words, the DSM has *become* madness- there is no madness that exists outside of the DSM and the mental illness simulacrum. Further, Foucault expresses his fear that "Perhaps someday we will no longer really know what madness was. Its face will have closed upon itself, no longer allowing us to decipher the traces it may have left behind" (Foucault et al.). Reason, society, history and all other conceptions of reality owe their existence to the signs and discourses that seem to represent them, but which are meaningless without this signification and representation (Plant). The components of this hyperreal world, in which all sense of real meaning and real experience is lost, exist only in their simulated and represented forms, and is only a simulation of its now non-existent self (Plant). As a result, it is no longer possible to glimpse the original reality of madness behind the simulated mental illness, which although the symptoms of mental distress have always been with us, I argue that the medicolegal idea of 'mental illnesses" as they are codified in the DSM have entirely supplanted the original experience of 'madness."

The acknowledgement that we are surrounded by copies, including a simulated world of mental illness, does not by itself have to induce hopelessness- it could instead spur a search for the 'original,' or the true real behind the apparent real (Plant). This has happened within the mental illness community in the reclaiming of the mad identity (Archibald). Social activists[68] have reclaimed language that has been used to oppress, such as "mad," "nutter" and "psycho." In addition, diagnostic jargon (described as symptoms) such as "auditory hallucination" and "psychosis" are promoted by mad activists to be replaced with the non-hegemonic terms "hearing voices" and "extreme experience" (Archibald). These activists subvert the medical language, which is the language of power and the language of the simulacra, to reclaim the original experience of madness and take back the power of their experience from the reign of scientific knowledge. Perhaps by using this language, there may appear a crack in the mental illness simulacrum, providing a bit of insight into the original state of madness. This exercise attempts to reclaim the reality of madness and wrest it away from the simulacrum of mental illness.

However noble this attempt at breaking through the simulacrum is, however, one questions how successful it will be. Is there really any way to break through the simulacrum, since the simulacrum is not only the representation of reality through signs, but the outright replacement of reality with signs. In other words, the original is destroyed by the simulation, suggesting that madness, as a condition, no longer exists. It has been replaced full force with the DSM and mental illness. The imaginary that anyone can release themselves from the simulacrum is a simulation. After all, the simulacrum gave us the terms "mad" and "psycho" as well as the terms "schizophrenia" and "obsessive-compulsive disorder."[69] Are these activists participating in merely another aspect of the simulacrum that appears to allow for dissent, but the dissent is just as much of as a simulation as is complicity with the medical model of mental illness and the DSM? In this way, mental illness as a simulacrum acts much like Marcuse's idea of capitalism in the One Dimensional Man (Marcuse). For Marcuse, capitalism is greedy and captures all dissent that comes it way, and by doing so, neutralizes it. Subversion and dissent, while they at first may appear to threaten the capitalist system, are soon subsumed into the system, and thereby lose their power. Although Marcuse does not use the language of simulations, it is straightforward

[68] Mad activists comprise a diverse coalition of psychiatric survivors, mental health service users, and allies who reject pathologizing medical models of mental distress, instead advocating for human rights approaches, self-determination, and the recognition of madness as a valid form of human diversity; organized through groups like MindFreedom International, the Hearing Voices Network, and Mad Pride events worldwide, these activists challenge psychiatric coercion while reclaiming stigmatized language through what has been termed "mad-positive" consciousness (Beresford and and Russo; Lefrançois et al.)

[69] Yet the terms 'mad' and 'psycho' simply provided cover-all terms for anything outside societal norms, while schizophrenia" and "obsessive-compulsive disorder and well-defined disorders that bear no resemblance to each other.

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to apply this idea to the idea of simulacra. Rather than capitalism being the simulation in question, however, the power that lies behind the simulation of mental illness is the supremacy of medical knowledge, and like capitalism, medical knowledge is flexible and all-encompassing in such a way that it can withstand subversion, ultimately rendering it harmless to the simulation. The simulacrum of mental illness contains within it not only the scientized model that appears within the DSM, but also the imaginary opportunity for dissent. Both are mere copies of their originals- madness and dissent no longer exist except in their represented form. According to Plant, we now must speak of the copy without a corresponding original, and the signs and symbols of madness with which we are surrounded only serve to reinforce the belief that something real is being represented. No amount of mad language is going to change that. The term "consumer" illustrates how the mental illness simulacrum absorbs opposition. Initially, mental health activists used "consumer" as resistance language against psychiatric authority (McLean). However, the psychiatric and medical establishments have since adopted this term into their own vocabulary. What began as language of protest has been co-opted by the very system that activists were challenging. This demonstrates Baudrillard's point about how systems of power neutralize resistance, making effective opposition seemingly impossible. Baudrillard demonstrated the futility of dissent and the impossibility of the success of "those who create disorder" (Vaneigem).

THE SURVEILLANCE SOCIETY AND PSYCHIATRIC CONFINEMENT

Baudrillard's four-stage process of the image, in which signs come to mask and eventually replace the fundamental reality to which they refer, aptly captures what has occurred around mental illness. The vocabulary of disorders within the DSM has superseded the basic reality of human madness through a hyperreal fiction. In Baudrillard's framework, a simulacrum becomes complete when representations no longer connect to any original reality but instead replace that reality entirely. I suggest that psychiatric terminology has reached this fourth stage where "signs have come to completely replace the real experience." In addition, I argue that we can no longer access the original experience of "madness" because it has been entirely subsumed by the clinical language and classification system of "mental illness." We now understand psychological distress only through the lens of diagnostic categories created by psychiatry, making it impossible to see or experience madness outside this constructed framework.

And just as Foucault's metaphor of the panopticon creates an ecstasy of control through imagined observation, so too does the simulated gaze of psychiatry induce real docility in patients via a false perception of constant scrutiny. Foucault painted the asylum as the penultimate example of surveillance society and social control (M. Foucault, *History of Madness*). Whether in the asylums of the pre-deinstitutionalization era, the modern-day state psychiatric hospital, or the "psych units" that exist in most mainstream hospitals today, inpatient psychiatric care is the premier example of surveillance, where it is not just the body, but the mind that is exposed to examination, evaluation, and control. There are no secrets in a total institution (Goffman) where simulated surveillance prevails (Bogard). When describing simulated surveillance, Bogard writes, "Simulated surveillance is an imaginary of absolute control, in a word, an ecstasy of control. Everything exposed, everything visible, graspable, naked, no secrets." Through cameras and two-way mirrors, the psychiatric patient is constantly under surveillance, and in some cases, cannot even undress, use the toilet and shower, or sleep without being surveilled. This simulated surveillance indicates the absolute social control that the psychiatric system has on the inpatient resident. Since the psychiatric institution is a simulacrum itself, so too is the surveillance simulated, but that does not make the surveillance any less effectual. In fact, simulated surveillance, like in the analogy of the panopticon, is even more effective than real surveillance, because it has totalizing power over the inmate (M. Foucault, *Discipline & Punish*).

Contemporary psychiatric inpatient environments maintain extensive surveillance regimes that substantially exceed monitoring in other healthcare settings, with patients' behaviors, movements, and even thoughts subject to continuous observation and documentation. Multiple studies confirm that formal observation protocols—where staff regularly monitor patients at intervals ranging from continuous (every 15 minutes) to constant visual observation—represent standard practice in virtually all psychiatric facilities (Chu; Bowers et al.). This surveillance extends beyond direct visual monitoring to comprehensive electronic systems: CCTV cameras in hallways, dayrooms, and sometimes seclusion rooms; electronic door systems tracking patient movements; and detailed nursing documentation requirements capturing patients' statements, behaviors, medication compliance, and social interactions (Muir-Cochrane et al.). For patients deemed high-risk, special observation protocols may include maintaining uninterrupted visual contact, even

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during toileting and bathing, with detailed documentation of every action taken, severely compromising privacy while creating digital archives of behavior that contribute to what some authors (Holmes) terms the "psychiatric dossier" (Curtis et al.). This pervasive monitoring creates a "transparency effect" where patients internalize the evaluative gaze and modify their behavior accordingly, demonstrating how psychiatric surveillance operates as both material practice and disciplinary technique in precisely the manner Foucault theorized.

While this critique examines psychiatric diagnosis and institutionalization through the lens of simulacra and surveillance, it is important to acknowledge the complex realities that clinicians face when working with individuals experiencing severe psychological distress. There are cases where temporary hospitalization may genuinely protect individuals from self-harm or prevent harm to others during acute crises. Many mental health professionals approach involuntary treatment as a last resort, used only when less restrictive alternatives have been exhausted and when the potential benefits significantly outweigh the costs to personal autonomy. These practitioners work within a system they may simultaneously critique, navigating ethical tensions between respect for individual liberty and duty of care. The perspective offered here does not seek to dismiss these legitimate clinical concerns but rather to examine the conceptual frameworks that shape and justify intervention.

What remains problematic, however, is how the simulacrum of mental illness creates the conditions under which these interventions become normalized and expanded beyond truly exceptional circumstances. The diagnostic apparatus, with its ever-widening categorical net, increasingly blurs the boundaries between temporary protective measures and extended social control. Even when hospitalization is initiated with genuinely therapeutic intent, the institutional machinery operates through mechanisms of surveillance and compliance that transform care into discipline. By recognizing the valid concerns that drive some clinicians' decisions while simultaneously critiquing the system within which those decisions are embedded, we can better understand how power operates through seemingly benevolent structures. This approach allows us to imagine alternative frameworks for responding to psychological distress that might better balance protection with respect for difference and autonomy, moving beyond the false binary of either abandoning vulnerable individuals or subjecting them to comprehensive surveillance and control.

In a surveillance society, especially with the simulated surveillance (Bogard) occurring within the simulacrum of mental illness, the constant gaze of power (whether actual or simulated) is the mechanism by which people are controlled. In the medical realm, Foucault called this surveillance the medical gaze (The Birth of the Clinic). The medical gaze as it is practiced within the simulacrum of mental illness creates an imaginary of total control of the deviant body of the mad (Bogard).

Bogard suggests that the clinical gaze destroys the natural body, which is then reconstructed, renovated and resurrected. He writes, “[…] brought back from the dead- designer bodies, cyborg bodies, sim-bodies.” Although he calls this creation of sim-bodies “smooth violence” as opposed to the “rough violence” of the clinical gaze (Bogard), it is violence nonetheless. The psychiatric patient living as an inpatient (or medicated outpatient) develops a simulated body by the taking of medications that cyborgify them into technologically corrected and docile bodies. In the simulacrum, all patients under its purview are made compliant using cyborg technology. A cyborg, as conceptualized by Haraway, is a hybrid of machine and body, and she notes that modern medicine is rife with these couplings between organism and machine. Cutting-edge medical technology such as the antipsychotic smart pill Abilify MyCite is a stunning example of cyborg technology, surveillance, and the social control of deviant bodies (Burrows)70, but more pedestrian technologies also create modified, enhanced, or docile minds and bodies. For example, while physical restraining practices within a psychiatric institution constitute surveillance and social control (and absolute, physical control), chemical restraint not only serves to control the mind and body, but melds the body with the medication, so the two become one. In the case of forced medication, chemicals course through a person’s veins, taking up residence there and in the brain.

The purpose of psychiatric inpatient care is ultimately the correction of deviant bodies, through the lens of “management of severe symptoms,” and it achieves this goal through the surveillance of mind and body. While the

[70] This control is masked under the guise of ensuring medication compliance and patient and community safety

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therapeutic model of psychiatric care certainly frames its purpose as enhancing function and alleviating suffering, a Foucauldian analysis reveals how these ostensibly benevolent aims operate simultaneously as normalization mechanisms. Both interpretations can coexist—psychiatric interventions may genuinely aim to reduce distress while simultaneously functioning as disciplinary techniques that correct "deviance" toward socially acceptable norms. The purpose of psychiatric inpatient care is presented as enhancing function and reducing suffering, yet through a Foucauldian lens, it simultaneously operates as a mechanism for correcting deviant bodies that transgress social norms (Fabris; Rose).Bogard writes, "Surveillance is always a dream of order, and that links it to a project of sterilization - ordered space is clean space. The production of sterile zones - times, places, bodies, cultures - is part of the general imaginary logic of surveillance and, like transparency, what links it to simulation generally and to its simulation in particular." The surveillance and cleansing of the mad and deviant body and mind are the goals and project of the psychiatric simulacrum, and the hospital. The simulation is clean, ordered, and organized, unlike life outside the hospital. Everything in the simulacrum is ordered and sterile. The simulacrum serves to "cancel the surface" (Bogard), by canceling the unclean mind and body of the inpatient.

In the classical age, the sovereign held the arbitrary right of assigning death (Foucault, The History of Sexuality, Vol. 1: An Introduction:), but in the modern age of the simulacrum, this power has been displaced by the formal power over life, or, as Foucault terms it, biopower (Bogard). The mental illness simulacrum and the hospital holds this biopower over its inhabitants. The distinction between holding the power over death or the power of life is an important one. Foucault's concept of biopower takes two forms- one focused on the discipline of the body and the other, called biopolitics, focuses on the management of populations (Aranson). Inpatient psychiatric treatment facilities aim to discipline the minds of their residents, by combining individual and group therapy, medications, and carefully structured activities. In other hospital settings that do not have as much structure, patients are left to sit by themselves, perhaps socializing with other residents. However well-structured a hospital is, the discipline of the mind is paramount.

The signs signifying mental illness that populate the DSM and create the mental illness simulacrum are ubiquitous in popular culture and society generally. People suggest that their dogs or spouses are 'bipolar,' that a disagreement with a coworker has left them 'depressed,' or that a fastidious relative is 'OCD.' These signifiers of mental illness have become a hegemonic tool that is part of a larger framework of social control that attempts to eliminate difference and cleanse the mind of the person with mental illness (Arrigo and Williams).

The social control of the deviant mad body is turned into the docile and yielding mind and body of the mental patient within the simulacrum of the DSM, especially as an inpatient. Involuntary hospitalization has been defended and justified as a means to protect society from the potentially unstable and dangerous behaviors of those marked as having a mental illness (Arrigo and Williams),71 although it is argued that danger, on its own, is not a disease (Szasz).72 However, scholars of the intersection between mental illness and social control, argue that this proposition is based on the following three inaccurate premises:

1. That mental illness is a real difference necessitating censorship.
2. That the mentally ill present a greater identifiable threat to society than the mentally healthy; and
3. That science possesses the key to understanding and treating mental disease or defect (Arrigo and Williams).

The primary difference between those living in the DSM-enhanced simulacrum and those who are not is simply that- mental patients are living in a particular simulated world, while those without a diagnosis are living in a different, although just as simulated, world. Those diagnosed with a mental illness receive a stigmatizing label, which in turn influences their self-meaning (Kroska and Harkness). Some authors argue that the fact of receiving a psychiatric diagnosis is itself a form of epistemic injustice (Hassall), although others note that some patients welcome a diagnosis because it "explains" what were previously unintelligible symptoms (Perkins et al.).

[71] Although "threat to others" is not listed in the DSM as a reason for hospitalization
[72] It is important to note that while many people with SPMI such as schizophrenia are indeed held, at last temporarily, involuntarily in psychiatric untis, many individuals diagnosed with SPMI labels are never hospitalized.

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The mental illness simulacrum relies on the myth of absolute scientific knowledge and expertise, as Arrigo and Williams suggest in their point three above. Psychiatry lays claim to holding scientific truth to justify the unjust treatment of people who are mentally different, but this scientific 'truth' is the web that holds the simulacrum together. Involuntary confinement advances psychiatry's tenuous grasp on power in the name of the privileged scientific mind (M. Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*). The whole of psychiatric classification, as codified in the DSM, is the structure that holds the mental illness simulacrum together. The existential status of people with mental illness is corrected and even sacrificed at the altar of medical knowledge and politics of psychiatric justice prevails (Arrigo). Confinement of noncriminal persons identified as having a mental disorder is a method of controlling and isolating the socially undesirable (M. Foucault, *History of Madness*), and is primarily a means of policing public hygiene, or ridding society of difference (Foucault, *Madness and Civilization*). This is a reflection of his concept of biopolitics, in that biopower is used to control and manage populations (Aranson). Although we don't often think of Foucault's notion of punishment as it is laid out in "Discipline and Punish: The Birth of the Prison" (*Discipline & Punish*) as relating to people with mental illness confined to hospitals, the social control of people trapped in the simulacrum of the DSM is still used to correct the minds and bodies of the mad (Arrigo and Williams).

Power must not only be considered in its negative connotations in terms of domination and oppression- it can also act as a positive force as it creates the world and all its simulations (Plant). In other words, knowledge applied in the name of power creates our reality, or the simulacrum which we inhabit (Plant). After all, it is knowledge, however fallible, that creates the DSM and all its many editions, thereby creating the simulacrum of mental illness. The simulacrum of mental illness, acting through power structures, create the conditions in which people allow the involuntary commitment of people with mental illness. In fact, it's not just a "turning of the head" or a tacit approval of this practice- sometimes it is made as an explicit practice codified into law. The recent example of New York City's mayor, Eric Adams, who instituted a mandatory hospitalization for houseless people who appear to have a mental illness, shows how the signs of mental illness do not always remain hidden, but present themselves to public view, often to much approval (Newman and Fitzsimmons).

CONCLUSION

While arising from differing philosophical traditions, Baudrillard's theory of simulacra and Foucault's analysis of power as a diffuse network of social control share important connections. Both contend that scientific and medical discourses wield tremendous definitional authority. The ability to demarcate sanity from madness grants psychiatry immense control over people's lives. Foucault recognized the historical contingency of mental illness categories, seeing them as instruments of biopower rather than reflections of objective pathology. What matters most is not any underlying 'truth' of illness but the classificatory power of the Diagnostic and Statistical Manual to shape social reality. Bringing together the perspectives of Baudrillard and Foucault allows us to fully apprehend how the vocabulary of the DSM has generated a self-referential, hyperreal fiction masking the basic phenomenon of human madness. Just as the omnipresent medical gaze induces real docility in patients who feel perpetually scrutinized, so does the simulated world of mental illness enforce very tangible discipline and control. In this sense, the reality or unreality of psychiatric categories makes little difference – their consequences remain equally grave. Those labeled as mentally ill face forced hospitalization, medication, and loss of rights in the name of scientifically authorized "compassionate" coercion. The ideological functions served by mental illness concepts thus continue irrespective of those concepts' validity. This represents the cunning duplicity of simulation and bio-medical power: their ends are achieved through appearance and performance rather than substance. Grasping madness as a Baudrillardian simulacrum reinforced by networks of Foucauldian social control therefore opens vital critical space. It allows us to transcend sterile debates over scientific legitimacy to confront more directly the violence done in psychiatry's name.

Despite the theoretical criticisms presented in this paper, it's important to acknowledge the nuanced ways some clinicians actually engage with the DSM in contemporary practice. Rather than treating diagnostic categories as rigid biological realities, many practitioners today approach the DSM as a pragmatic tool for communication and treatment planning. The DSM serves primarily as a common language that helps clinicians describe symptom patterns and determine appropriate interventions, while acknowledging the inherent limitations of categorical approaches to understanding human suffering.

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Some clinicians now adopt what might be called a "DSM-informed but not DSM-limited" approach, recognizing that standardized diagnostic criteria can provide useful structure while remaining aware of their socially constructed nature. This more sophisticated clinical stance acknowledges that diagnostic categories are provisional heuristics rather than natural kinds, useful for guiding treatment but insufficient for capturing the full complexity of an individual's lived experience. Nevertheless, institutional structures—including insurance reimbursement systems[73], research funding mechanisms, and legal frameworks—continue to reinforce the primacy of DSM categories, ensuring their continued influence regardless of clinicians' personal philosophical orientations toward diagnosis.

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[73] Having a DSM diagnosis may provide a person with options for treatment, for example.

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