Chapter 2: History of Madness and Psychiatry

> If the endeavour to reconstruct this historic context provides a certain interest today, it is because this past of mental medicine is not yet dead.
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> (Castel, 1983: 261)

To understand and embed Kempe's and Barnes' narratives in their cultural and historical contexts necessitates a critical appreciation of the history of madness and the emergence of psychiatry as the dominant paradigm for understanding it. Historians such as Foucault and Roy Porter and sociologists such as Andrew Scull and Nikolas Rose have charted understandings and treatments of madness over time, and this chapter aims to provide a synopsis of these differing perspectives for two reasons. First, to delve into the history of madness is not an academic exercise, nor is it an escape from present day concerns regarding mental health. As inferred in Castel's quote above, the ways in which madness has been construed in the past has critical implications for its present status and treatment. Second, the aim of this research is to examine first hand accounts of madness across different historical periods, which necessitates an understanding of the complexities of the ways in which the meanings of madness have shifted in human consciousness. As stated by the editors of *The Anatomy of Madness* (volume one):

> the recognition and interpretation of mental illness, indeed its whole meaning, are culture-bound, and change profoundly from epoch to epoch, in ways inexplicable unless viewed within wider contexts of shifting power relations, social pressures and ideological interests.
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> (Bynum, Porter and Shepherd, 1985: 4)

The structure of this chapter is broadly based on Foucault's distinction of three different eras of madness presented in his newly translated book *History of Madness*. It is important to emphasise that what Foucault explores in his book is not a history of a disease, its treatments or its institutions. Rather what he presents is the history of a division between madness and reason, a separation "through which a reality splits into radically different parts until a new realisation takes place, a synthesis which in itself is a new reality" (Khalfa, 2006: xv). Foucault identifies three epochs which define this fundamental division between madness and reason in Europe: the Renaissance, the Classical Age and the Modern Experience of Madness. *The Renaissance* examines the way madness was perceived and treated until the early seventeenth century. Foucault argues that this period was dominated by a dialectical relationship between madness and reason, where madness became a reflection on wisdom that was epitomised in the figure of the fool. *The Classical Age* charts the sharp separation of reason and madness in the seventeenth and eighteenth centuries, with madness shifting in meaning to unreason. This was a period that witnessed the rapid growth of institutions and the confinement of the mad as part of a social subclass. *The Modern Experience of Madness* follows the development of madness as an object of science, together with the emergence of asylums, technologies, knowledge and professionals. It is this period in the history of madness where madness becomes construed as an axiom, an object and a disease. This chapter, which charts the historical emergence of madness and psychiatry, closes with an exploration of how psychiatry and resistances towards it have developed in the twentieth century.

The Renaissance

Madness has been present throughout human history. Archaeologists have unearthed seven thousand year old skulls that show evidence of trepanning, a well known phenomenon where small round holes are drilled into the skull to release evil spirits (Porter, 2002: 10). There is also written testimony of madness, for example in the Old Testament where Nebuchadnezzar was punished by God by being driven into bestial madness. Homer wrote of Ajax killing his sheep under the delusion that they were enemy soldiers (Porter, 2002:12) and a few hundred years later, Socrates was contemporarily recorded as experiencing and being directly influenced by a daemon voice (Leudar and Thomas, 2000). It seems therefore that there have always been people who have heard voices, but that this has not always been related to madness. Until the middle of the seventeenth century, phenomena such as voice hearing or convulsions were perceived as a special or sacred form of knowledge. Christianity viewed such individuals as supernaturally possessed by either divine or demonic spirits (Porter, 2002: 123). Thus madness was closely related to religious experience and in this respect Foucault suggests the mad both revealed and belonged to the limits of the world. This, he argues, was exemplified in the literary construct the *Narenschiff* or the *Ship of Fools*, an important literary object filled with imaginary heroes, moral models and symbolic voyages (Foucault, 2006a: 8-12).[1] However, the Ship of Fools is not purely a literary device. As a means of dealing with the mad, there is also evidence for their actual existence as boatmen given the task of ridding the cities of the mad, depositing them someplace else. The Ship of Fools therefore is laden with meaning, highlighting the liminal position of the mad in medieval society and, as a metaphor, Foucault argues that the position of the mad has always been, and remains, one of exile

and marginalisation from society. Whilst Foucault highlights the importance of the Ship of Fools as a medieval symbol of liminality, it was not a widespread phenomena across medieval Europe. Undoubtedly, there are accounts of mad people wandering at will throughout the European landscape of the Middle Ages, but they were more commonly located in one community and cared for within the family, who received financial support through parish funds, permanent pensions or taxation levies (Scull, 1993: 15). The popular conception of the medieval mad being held in stocks, beaten or drowned, whilst having some basis in historical fact, were not systematic or commonplace 'treatments' (Samson, 1995). Rather, the mad were tolerated within the community and helped by a variety of people, for example clerics, medics, apothecaries, astrologers and folk medicine (Scull, 1993: 176). Even if viewed as shameful to the family, the mad were very much a domestic responsibility, being restrained or hidden in the home, in cellars, cages or pigpens (Porter, 2002: 90). So whilst asylums such as St. Bartholomew's and Bethlem were being established (1123 and 1247 respectively) they had very few numbers (in 1403 Bethlam had six patients rising to just twenty by 1598 Foucault, 2006a: 110).

One of Foucault's central arguments in relation to the Renaissance is that there existed an interdependent relationship between madness and reason. Contemporary writings, for example Shakespeare, often portrayed the mad or the fool as central figures and "guardians of the truth" (Foucault, 2001:11), thus a pivotal feature of madness was that it revealed the truth and essential wisdom to the other. In the New Testament, it was those with "unclean spirits" who recognised Jesus' identity as the Son of God. In Germany, there is an old proverb that translates as "only children and madmen tell the

[1] The Narenschiff is evident across a variety of fifteenth century art forms such as music, painting and

truth". In Hamlet, Shakespeare asserts that there is "method in his madness", suggesting that in Elizabethan times madness could be motivated and goal-directed (Szasz, 1997: 122-3). Madness was also perceived as a dark power belonging to the underworld that existed to instruct the wise and highlight faults in human nature (Foucault, 2006a: 26). In this time, argues Foucault, madness became a mirror in which the truth of man could be perceived (Foucault, 2006a: 23). In this mirror of madness, the truth of morality, nature and humanity were reflected to the non-mad, thus a dialectical relationship was formed between madness and reason, as Foucault describes:

> Madness becomes a form related to reason, or more precisely madness and reason enter into a perpetually reversible relationship which implies all madness has its own reason by which it is judged and mastered, and all reason has its own madness in which it finds its own derisory truth. Each is a measure of the other, and in this movement of reciprocal reference, each rejects the other but is logically dependent on it. (Foucault, 2006a: 28-9)

All madness therefore had its reason and all reason its madness in which could be found some form of truth.

The Classical Age

The Classical Age sees the breakdown of the dialectical relationship between madness and reason, epitomised in the philosophy of Descartes. For Descartes, knowledge had to be based on certainties and the only thing we know with absolute certainty is that we exist as thinking beings. He concluded that it is not our bodies that we know best but

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poetry (see Foucault, 2006a: 8-12).

our minds, and our true self is revealed when we engage in rational activity (Johnson, 1987). When thinking or the ability to doubt is lost, our rationality, what distinguishes us from lower animals including the mad, also disappears (Foucault, 2006a). Following Descartes, madness could no longer sit alongside reason, but instead was set in opposition to, and excluded from the realm of reason. Madness became unreason. This had critical consequences for the social positioning of the mad. No longer were they tolerated in the home or sent to the limits of the town, they were incarcerated with other perceived social undesirables, being viewed as part of a wider sub-class of deviants, criminals, physically handicapped and the poor (Scull, 1993: 1).

This separation of madness from reason was part of a wider phenomena known as the Enlightenment, a period of time during which significant changes in Western society took place, with the focus on the individual and increased secularisation. Religious, spiritual and occult understandings of the world lost their power during the Enlightenment, which gave rise to more scientific, rational explanations. The work of philosophers such as Descartes and Newton initiated a shift in belief from the immaterial to the material world, and thus the observable, measurable world of science. Descartes, building on the work of Hippocrates, was particularly influential in the emergence of medicine as a distinct phenomenon, separate from the religious and spiritual underpinnings it had long been associated with. He deduced that Creation could be divided into matter (the body) and mind. This Cartesian dualism had a crucial impact on understandings of madness. The mind according to Descartes was connected to the body via the pineal gland (mid-brain), therefore madness originated in the body,

just like other physical ailments (Porter, 2002: 57-8).[2] Under such philosophical developments, medicine and the church separated, with the former developing its own professional identity.[3]

Foucault argues that the rational, scientific knowledge developed by materialists such as Descartes and Hobbes to all intents and purposes silenced and oppressed the "mad". He contends that madness, now located within the physical body, effectively replaced leprosy in society's consciousness, with the mad occupying the space that the lepers had left (Foucault, 2006a). Historically, lepers were rejected from society and exiled, left to their fate amongst the mass of other lepers from which it was pointless to differentiate (Foucault, 1979: 198). With segregation came a decline in the disease and, as a consequence, a decline in the number of leprosy hospitals. Foucault argues that society felt compelled to re-establish the institution and contain a section of society. As the population chosen for this incarceration, the mad ceased to be tolerated and instead were to be feared as contagious and, as such, separated from society. Whilst some critics dispute the negative correlation between the decline of leprosy and the rise of the contained madmen presented by Foucault, what is of critical importance in his analysis is that whilst leprosy all but disappeared in Western Europe, the values and images attached to the leper, in particular the fear of this contagious figure, lasted far longer in the consciousness of society (Foucault, 2006a: 5). For the mad, this was a change of status. Prior to the Enlightenment the insane were conceived as supernaturally possessed, with the witch and the holy fool free to wander in the community and free to

[2] The work of Descartes was further developed by other materialists, most notably Hobbes, who denied the existence of anything in the universe but matter. For Hobbes, knowledge and behaviour was determined by the sensual and physical world. Voice hearing and visual hallucinations resulted from a fevered brain as opposed to supernatural powers (Porter, 2002: 59).

speak. Any empowering features madness gave them were lost through incarceration, as like the lepers they were rejected, exiled and treated like animals, their reason denied, their voices silenced.

Foucault describes this widespread incarceration as the great confinement of Western Europe, although he has been criticised for over-generalising in this often quoted statement (Porter, 2002: 93; Doerner, 1981). However, in the fuller translation of his writings on madness, he details how this confinement related to not just the mad who comprised only a small percentage of inmates, but others who were deemed as idle, deviant and a threat to the emerging industrial economy (Foucault, 2006a). For example, England only had a small amount of insane people in asylums, with the majority being accommodated in workhouses and bridewells (Porter, 2002: 94). However there is sociological agreement that confinement was intrinsically linked through industrialisation to the need for labour and societal condemnation of idleness, which was perceived as the ultimate evil (Foucault, 2001:43). The societal community of labour "acquired an ethical power of segregation, which permitted it to eject, as into another world, all forms of social uselessness" (Foucault, 2001:54).

This theory of the confinement of deviants (including the mad) being linked to idleness is not merely a functional argument related to capitalism, as Foucault argues, it is an ideology that persists to the present day, for example through diversionary and occupational activities. Madness became a condition that not only afflicted the social body, but threatened social order. Rose describes how "medical rationalities provided the matrix within which government problematized the population", with madness

[3] It should be noted that the medical treatment of madness has longstanding origins in Greek, Arab and

being a key condition framed within this moral paradigm, reflecting the negative of a moral society (Rose, 1994: 56). As Foucault describes; "the walls of confinement actually enclose the negative of that moral city" (2001:56-7). This is a point of departure in the history of madness; madness now becomes problematic, a phenomena to be hidden away and imbued with shame.

> In the history of unreason, it signals a decisive event: the moment when madness is seen against the social horizon of poverty, the inability to work and the impossibility of integrating into a social group. It was the moment when it started to be classified as one of the problems of the city. The new meanings assigned to poverty, and the importance accorded to the obligation to work and the ethical values surrounding it were ultimately determining factors in the experience of madness, transforming its meaning. (Foucault, 2006a: 77)

However, Foucault goes on to reject a Marxist critique, contending that it was the classical age's intolerance of the "immorality of unreason" that led to the widespread incarceration of the mad, rather than the maintenance of economic and central state power (Ingleby, 1983:147). As argued earlier, for Foucault in the Classical Age, madness ceased to be the mirror of reason and instead became separated from it, becoming unreason. Unreason was hidden in the institutions of confinement and related to contemporary moral codes around sexual deviance, sacrilegious behaviour and *libertinage*, a form of freethinking. Unreason was therefore shameful and by confining it, reason developed a discourse about unreason which helped maintain the social order of the classical age. However, Foucault goes on to make a further distinction between

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Oriental medicine. For example in the Arab world, there were hospitals for the mad in Baghdad and Fez

unreason and madness. Whilst unreason was immoral, a path freely chosen, madness on the other hand was viewed as bestial, the lowest order of God's creation. This classical view of madness had little in common with the nomadic mad of the middle ages. Classical madness, whilst confined, still had a public profile, but it became an organised spectacle, a theatre of cruelty as the mad were publicly displayed behind the bars that confined them (Foucault, 2006a: 143). Via these human zoos, the mad were used as moral lessons on the vices of, for example, drink, sin and lust, so that like their criminal inmates, the mad were used as a source of moral instruction long before they became objects of scientific scrutiny (Foucault, 1979). The qualities that make us human were therefore seen to be absent in the mad, who had no reason and no humanity necessitating anything other than brutal treatment (Ingleby, 1983:147-8).

Bringing this section to a close, the Classical Age sees two developing perspectives: an ethical perspective on madness and a naturalist perspective (Foucault, 2006a). The ethical perspective considered madness as a freely chosen path against reason, a choice that could be reversed by a system of constraints and rewards. Thus unreason was related to a lack of moral order. The naturalist perspective viewed madness as a natural object worthy of scientific study. Crucially, it is from both of these perspectives that the Modern Experience of Madness emerged at the end of the eighteenth century, with the creation of institutions exclusively oriented to the treatment of the mad. Foucault summarises the Classical Age thus:

> The key point was that madness was suddenly invested in a social world, and was granted there its own privileged and quasi-exclusive place almost from one

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as early as the seventh century (Foucault, 2006a: 117).

> day to the next (across the whole of Europe in the space of fifty years), a clearly delimited terrain where it could be observed and denounced by all. Gone were the days when it sneaked through alleyways and hid in familiar places: now madness, and all those who were its incarnation, could be instantly exorcised through measures of order and precautions of police.
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> (Foucault, 2006a: 102-3)

The Modern Experience of Madness

As outlined above, the shift in the cultural meaning of madness did not occur in a social vacuum. With the growth of industrialism, society was becoming commercialised, the world was becoming smaller with developments in transportation, and the ability of humans to intervene in the natural world was increasingly evident (Scull, 1993: 104-5). The emergence of the industrial age witnessed a breakdown of old communal and authority regimes which resulted in a class crisis, with a generalised fear of the lower classes (Mayer, 1983: 17). In order to replace communal authority, a new ideology of self-discipline needed to be instilled. This was aligned with the work ethic of punctuality, industry and thrift, or what Mayer describes as a "middle class morality" (Mayer, 1983: 17). Just as the poor became a valuable currency in the external expansion of society, for example as workers or soldiers, the mad, via their social exclusion, also performed a function in the internal expansion of society, enhancing self-understanding and helping to construct identity (Doerner, 1981:51). Such a fundamental philosophical shift was reflected in the cultural understanding of madness, where demonological, animalistic conceptions were replaced with more naturalistic understandings. John Locke proposed that humans are born as a blank slate *(tabula rasa*), with all our ideas emerging from sense experiences and, as such, we are shaped

by education and experience. Insanity for Locke was a product of disturbances in association or faulty cognition, thus there was a move towards internal, mental explanations. This was a fundamental turning point in both the understanding and treatment of madness. If madness resulted from faulty cognition and education, those affected could be retrained to think properly (Porter, 2002: 60). For the first time, madness is constructed within a pedagogic paradigm, with the lunatic as the child, malleable to re-education within the right learning environment (Castel, 1983: 256). With insanity now seen as a defective human mechanism, it was deemed treatable and the eighteenth century witnessed a dramatic development in scientific explanations and treatments (Scull, 1993: 41).

For the mad, there were two important movements that shifted understandings and meanings of madness during this time: first, the separation of madness from other perceived degenerates and, second, the beginnings of a classification system of different forms of madness. In relation to the first movement, the low status of the mad in seventeenth and eighteenth century institutions was an initiating factor in the development of asylums, as the poor and degenerate voiced their protests against confinement, in part motivated through a fear of becoming mad (Foucault, 2006a: 398). The opinion was formed that criminals deserved better treatment than to be locked away with the insane (ibid: 397). This reflected a wider phenomena where the social space of sickness became separated from poverty and crime (ibid: 414-5). Alongside of this increasing demarcation between the madman and other inmates, there was an increasing differentiation within the construct of madness itself. Forms of madness began to be identified: insane, feeble-minded, lunatic, imbecile and frenzy. Foucault charts the evolution of these categories in one French institution: three or four categories on the

register of Saint-Lazare in 1721; fourteen in 1728; and sixteen in 1733 (Foucault, 2006a: 389).[4] Foucault describes this rudimentary classification as the 'penetration of reason into the domain of madness' (ibid: 393). These two phenomena, the separation of madness from crime and poverty and the identification of different forms of madness, had three consequences. First, the emergence of asylums exclusively to house the mad, initially as private madhouses and, after the Reform, as public asylums. Second, the beginning of the 'medical science of madness', what is traditionally known as classical psychiatry. Third, madness becomes wholly isolated and disengaged from reason, criminality and poverty, a solitude 'which came to form a neutral empty zone around it' (Foucault, 2006a: 419).

Moral Treatment

This paradigmatic shift was fundamental to the response to madness that became the Reform movement, but was initiated by Samuel Tuke in England and Philippe Pinel in France in the late eighteenth century. Tuke and Pinel set up radically different treatment facilities and regimes to those of the private madhouses, through the employment of diversional, recreational and benevolent therapies, which became known as moral treatment. The Retreat in York was established by the Quaker Tuke in 1796 in response to the death of a young, female Quaker shortly after her admission to a private madhouse.[5] As an institution, The Retreat was therefore part of a larger protest against private asylums. Madness for Tuke and his contemporaries was seen as a consequence

[4] Increasing degrees of differentiation and their categories continues to multiply today, an issue I shall return to in Chapter three in relation to the Diagnostic and Statistical Manual for Mental Disorders (DSM).

[5] The Quakers had a history of engaging with the debate between religious experience and madness. They considered many religious experiences to lie between reason and madness, and were often forced to defend their sanity. Consequently, Foucault argues, they had a heightened awareness regarding the treatment of the mad (Foucault, 2006a: 465-6). It is perhaps not inconsequential that the founder of the Quaker movement, George Fox, was a voice hearer.

of straying from the path of both nature and society. Tuke's aim in The Retreat was to heal madness by restoring and bringing together both natural man and social man (Foucault, 2006a: 474). However, Foucault directly challenges this humanitarian perspective, arguing that there were three principles central to its system of management: fear, work and the gaze (Foucault, 2006a). The fear Foucault refers to was not the external force of physical brutality, but the internal force of morality and conscience; "Fear here was directed straight at the patient, not through any instrument, but purely by means of discourse" (Foucault, 2006a: 484). A second feature central to moral treatment was work as a power to constrain, submit, regulate and fix patients in a system of responsibility (Foucault, 2006a: 485). There was little production value in this work, rather it acted as a moral rule, instilling a work ethic as part of its treatment. The third means of managing patients within the moral treatment was the gaze, in particular the desire to please managers and keepers, exemplified in the jostling for esteemed positions at the directors' tea parties (ibid: 486). Encompassing these three principles of management was a form of pastoral power over the subordinate patient, with the primary tool of psychological control being the system of reward and punishment within a paternalistic, family construct (Ingleby, 1983: 152). The family of the asylum represented "an island of healthy, natural authority in an anarchic society" (Doerner, 1981: 80). Thus the treatment founded in The Retreat could be seen as a form of hegemonic social control, establishing:

> a fundamental inequality between patient and therapist [gathering] together in the latter's hands all the positive attributes of the relation (knowledge, power, respectability etc.). (Castel, 1983: 259)

Through these three forms of control, fear, work and the gaze, there is a transformation in the relationship of power, from one premised on violence (imprisonment, restraint, beatings) to one based on discipline, an argument I will shortly explore in relation to Bentham's panoptican (Foucault, 2006b: 29). Foucault argues that this disciplinary power, whilst not violent, was still a form of physical power, as its point of application was always the body (ibid: 14). Within the disciplinary power set out by the moral treatment, two critical features were brought together that were to be central to the development of public asylums in the nineteenth century: surveillance and judgement. As Foucault simply states; "something was born here, which was not repression but authority" (Foucault 2006a: 488).

The Reform

As stated earlier, Tuke's Retreat was part of a larger protest against private madhouses that gathered momentum in the early decades of the nineteenth century and became known as the Reform movement. Presented as a benign and benevolent movement, the Reform was underpinned by two social movements; Benthamism, a pragmatic movement underpinned by ideals of expertise and efficiency; and Evangelicalism, a paternalistic and humanitarian movement (Scull, 1993: 84).[6] The arguments of the Reform movement reflect the rationale for the closure of the asylums 200 years later; asylums were factories of madness as "[patients] are subjected to the very circumstances most likely to confuse or destroy the most rational and healthy mind" (John Conolly 1830 in Scull, 1983: 129). John Reid in his classic 1789 text *De Insania*, anticipated

[6] Benthanism is named after Jeremy Bentham, who viewed the organization of society and man as functional and utilitarian (Doerner, 1981: 72). For the incarcerated, be they mad, poor or criminal, this meant containment with minimum cost and maximum efficiency. In 1791, Bentham proposed a new architectural design to achieve this, the Panoptican or inspection house. The impact of this architecture as a form of social control is discussed more fully in the next section (see page 37).

Goffman and Szasz by more than two centuries, describing mental hospitals as "nurseries for and manufacturies [sic] of madness", where inmates learnt how to act mad, thus becoming more mad (Reid 1816 in Scull, 1983: 128-9). For men such as Conolly and Reid, rather than curing madness, asylums for many inmates authenticated and constructed it:

> [Medical men] have sought for, and imagined, a strong and definable boundary between sanity and insanity, which has not only been imaginary, and arbitrarily placed, but, by being supposed to separate all who were of unsound mind from the rest of men, has unfortunately been considered a justification of certain measures against the portion condemned, which, in the case of the majority, were unnecessary and afflicting…Once confined, the very confinement is admitted as the strongest of all proofs that a man must be mad.
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> (Conolly 1830 in Scull, 1985: 128)

Connolly in particular is heralded as a Victorian hero who pioneered the non-restraint method in England.[7] However, whilst early in his dubious medical career he was a stern critic of private asylum treatments, at the end of his career, under professional and financial pressure, he obtained his income from the private trade in lunacy. He not only adapted his own house to take in a small number of female patients, but also had interests in two other private asylums, as well as receiving both a salary and a percentage of patient's fees from his position as consultant physician at Moorcroft House Asylum, receiving payments for consigning people (Scull, 1985: 129-31).

[7] In fact, Connolly was not the pioneer of the non-restraint method in public asylums in England. This is attributable to a young house surgeon at Lincoln asylum, Robert Gardiner Hill. Connolly not only refused to acknowledge Hill in this respect, he actively obstructed Hill's efforts to assert his claims (Scull, 1985).

As indicated by the shift in Connolly's position from asylum critic to asylum keeper, the reform of the management of the mad was by no means a simplistic humanitarian crusade. Whilst the movement acknowledged the inhumanity of the treatment and living conditions of the private madhouses, they were unable to conceive of an alternative that would contain the mad as effectively as the brutal treatments they witnessed, and consequently for some time they deferred to the "experts", supporting the cruel practices they condemned (Scull, 1993: 90-1). For the reformers the key question was therefore not how to eradicate the asylum system, but how to modify it, making treatment more humanitarian. Moreover, the reformers' position was not just about the banishment of brutal regimes, it centred on the redemptive and restorative power of the asylum as a place of cure (Scull, 1983: 132). Just as the prison reforms were aimed at ending punishment and restoring the rehabilitated criminal to society, so too the asylum reforms focussed on ending madness (Foucault, 1979). Like Tuke's Retreat, these new asylums were not intended to be hospitals, but correction houses instead. It was not long, though, before the boundaries between hospital and correction house were blurred. Thus, as I shall shortly go on to explore in greater detail, asylums began a process of transformation into medical spaces.

Foucault (2006a) viewed the moral treatment, and the reform movement it instigated, as oppressive forces, more damaging than shackles because of their covertness. For example, he saw Connolly's campaign for 'no restraint' as superficial, arguing that the imposition of authority through systems of reward and punishment was fundamentally a form of physical power (Foucault, 2006b: 104-5).However, Foucault has been criticised

for over-schematizing a complex story and decontexualizing the motivations behind the movement. Grob argues that at the time, it was a minority who saw the reform movement as a mechanism for maintaining social order. Most were unaware of any political considerations, their primary aim being to relieve human suffering (Grob, 1973 in Scull, 1983: 123). For Grob, criticising the benevolence behind the movement from a twentieth century perspective, takes the reformers' intentions out of context. As Mayer states: "the reformers would probably have had greater difficulty…in recognising the motives…[ascribed] to them from their own stated intentions" (1983: 21). In one sense, arguments over whether the moral treatment and the reform movement it instigated were benevolent or ruthless are immaterial; it still had at its core the principle of imposing dominant social norms onto what were perceived as disordered people (Castel, 1983: 260-1). The struggle between the two social movements underpinning the reform, Benthamism and Evangelicalism, has left its legacy in present day psychiatry, providing the foundations on which psychiatric treatment is still based; for example, therapeutic communities and occupational, diversional, recreational and behavioural therapies (Castel, 1983: 261). It also unwittingly prepared the ground for mass systems of institutional conformity witnessed in the nineteenth century.

The Rise of the Asylum

The rapid growth of industries and technologies in the eighteenth and nineteenth centuries meant that society was no longer able to carry deviants such as the mad (Scull, 1993: 26). In addition, within the new capitalist social system, the poor had fewer physical, financial and psycho-social resources to aid their support of mad relatives, thus they became a burden to both family and state (Scull, 1993: 33). Consequently,

there was increased demand for the mad to be institutionally accommodated and separated from society as surplus to the capitalist economy, thus maximising the labour force and removing the threat to social order (Scull, 1993: 39). Asylums turned no one away; anyone whose behaviour was judged intolerable was likely to be incarcerated. So lay definitions of acceptable and unacceptable behaviour gained influence in demarcating the sane from the insane. Scull (1993) hypothesises that asylums encouraged this intolerance, thus broadening definitions of madness, whilst maximising its market, with asylums becoming "a dumping ground for a heterogeneous mass of physical and mental wrecks" (Scull, 1993: 372).

Based on the perceived success of moral treatment, the reformers proposed that all mad people be housed in asylums. Rather than the traditional private madhouses, these were to be reformed institutions, where people could engage in leisure and occupational activities, where the patient's welfare was paramount, and where patients and staff would reside together as a family (Scull, 1993: 148). However, the utopian ideal did not translate to reality. As a result of the Lunatics Act of 1845, asylums were compulsorily erected throughout England. These were expensive to build, run and staff, so that consequently costs were kept to a minimum. The reformers' ideals of building architecturally pleasing buildings with a stimulating environment of galleries, music and artists' rooms were viewed as unnecessarily costly, particularly as most patients came from the lower classes (Scull, 1983: 153). Instead, patients had a monotonous existence in adequate accommodation within drab, prison-like institutions (Scull, 1993: 167). As Scull describes them, asylums turned out to be "museums for the collection of the unwanted" (Scull, 1993: 370) and whilst the following quotation comes from Foucault's analysis of prison reform, it is equally applicable to the reform of asylums. Describing

the movement from public executions to detention in prisons he states; “it is the transition from one art of punishing to another, no less skilful one. It is a technical mutation” (Foucault, 1979: 257).

The emergence of asylums was paralleled by the creation of other total institutions such as prisons, workhouses and juvenile reformatories, with which there are obvious similarities. All were products of the philanthropic reform movement, all were organized around the order of surveillance and control, and all reinforced the reformative powers of labour, religion and routine (Ignatieff, 1983: 82). Isolation from the outside world was a key feature of these institutions and, for the mad, was premised on avoiding the antecedents of their insanity and restoring the spirit. Solitude allowed space for spiritual reflection, so that the institution was not solely an administrative apparatus, but “a machine for altering minds” (Foucault, 1979: 125). Isolation was also disciplinary enclosure, a means of preventing violence in society and calming the fears of the public, thus the institution was a societal instrument used for the maintenance of social order. Institutions were transparent spaces where the mad and dangerous could be partitioned, located, supervised, assessed and judged (Foucault 1979). This was an important transformation in the treatment of the mad. To return to the leper, their mass exile was motivated by the desire for a pure community. Foucault contrasts this to the outbreak of the plague, where people were segmented in order to reduce outbreak and anarchy; in other words partition was motivated by the desire for a disciplined society. What Foucault describes happening in the nineteenth century was a coming together of these social motivations (Foucault, 1979: 198-9). For the mad and other institutional inmates, incarceration was motivated by the twin desires for a pure community and a disciplined society.

Coercion was used within the reform institutions to mould the inmates through techniques such as timetables, compulsory activities, silence and repetition (Foucault, 1979). The establishment of rhythms and control of activity by institutions served multiple purposes: to eliminate idleness; to avoid preoccupation (e.g. with criminal or mad thoughts); and to transform the individual via occupation towards a fixed norm. The most powerful tool in coercion however was observation and the material manifestation of this was evident in the architecture of the reform institutions. The building itself was a carceral mechanism which aimed to transform individuals through a combination of coercion, reward and punishment. Foucault describes institutional architecture thus;

> architecture …is no longer built simply to be seen…, or to observe the external space…, but to permit an internal, articulated and detailed control – to render visible those who are inside it; …an architecture that would operate to transform individuals: to act on those it shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them. (Foucault, 1979: 172)

The Panoptican design that embodied this all-seeing architecture, whilst devised in the eighteenth century, came to fruition in the nineteenth century. Its designer, Bentham, describes the Panopticon not as a schema or template for institutional architecture, but as a mechanism, which means for Foucault a mechanism of disciplinary power (Foucault, 2006b: 74). The building had corridors of locked and barred rooms circling around a central building or tower, from which inmates could be seen at all times, with

minimal staffing (two or three at the most). The tower was a central point of surveillance, which illuminated all that had to be seen, whilst providing a single gaze. This central observation cell was often constructed in such a way that the observer could not be seen by the inmates. The power of surveillance on the bodies of the inmates was therefore exercised irrespective of the actual presence of the observer (ibid: 76). Conversely, the cells of the inmates were constructed to make them permanently visible, therefore the power exercised, whilst ever present, was only ever an optical and psychological effect (ibid: 77). Bentham glorifies the Panopticon for its ability to exercise this form of power: it "gives a herculean strength to those who direct the institute" and constitutes a "new mode of obtaining power, of mind over mind" (Bentham, 1995 [1791] in Foucault, 2006b: 74). Foucault describes the primary effect of the Panoptican was "to induce in the inmate a state of consciousness and permanent visibility that assures the automatic functioning of power" (Foucault, 1979: 201). The Panoptican perfected the exercise of disciplinary power, providing a constant pressure whilst simultaneously reducing the number of those who exercise the power and increasing the number on whom it is exercised (Foucault, 1979: 206).[8]

In the asylums, the need to contain came first, thus the disciplinary space of the Panoptican gave rise to medical space. Within this theatre, medical performances were played out. The mad were observed and assessed, differences were drawn up between symptoms and behaviours, classifications were constructed and inmates were segregated according to their category. The mad were therefore a productive source of knowledge (causes of insanity, its control and cure) and skill (moulded in order to become a

[8] Whilst the Panopticon as an architectural design eventually failed, its influence is evident in Victorian asylum architecture, with wings and corridors radiating from a central tower. An informative website on the history of asylums, including architecture has been developed by the University of Middlesex (see http://www.mdx.ac.uk/WWW/STUDY/asyarc.htm).

functional part of society). For Foucault, power is not negative or repressive, it is positive and productive (Foucault, 1979: 194). The formation of knowledge and exercise of power form a symbiotic relationship with a mutual reinforcement of the other:

> The Panoptican functions as a laboratory of power. Thanks to its mechanisms of observation, it gains in efficiency and in the ability to penetrate into men's behaviour, knowledge follows the advances of power, discovering new objects of knowledge over all the surfaces on which power is exercised.
>
> (Foucault, 1979: 204)

Foucault goes on to describe this as an "epistemological thaw through a refinement of power relations" (ibid: 224). This is a form of disciplinary power that is not specific to psychiatry, rather it is a form of power that transcends institutions, culture and history, thus it is evident in issues of race, class and gender for example, as well as in institutions such as psychiatry (Foucault, 1982: 212). This form of power is always evident by the way it categorises individuals, attaches identities to people, and imposes laws and moral frameworks. In Foucault's words:

> it is a form of power which makes individuals subjects. There are two meanings of the word *subject*: subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to.
>
> (Foucault, 1982: 212, emphasis in original)

As a form of power, and this is particularly pertinent to psychiatry, it demands knowledge of the inside of people's minds and souls in order to produce truth, both of the individual and wider society (Foucault, 1982: 214). Crucially, as seen in the design of the asylums, it is a power that is distributed, an all pervasive continuous control, whose premise is internal governance and, as such, is essentially embodied. However, power cannot be analysed by itself, as it does not exist without the other: teacher/pupil; employer/employee; psychiatrist/patient. Thus the relationship between the parties has to form the basis of any analysis of power. Moreover power can only be exercised within this relationship, amongst the "actions that modify the actions of others" (Foucault, 1982: 219). Crucially, this mode of action on others does not necessarily take place immediately; rather it acts across time and space, having the potential to act on human actions both in the present and the future (Thomas and Bracken, 2008). It is, as Foucault goes onto argue, a form of government which "designate[s] the way in which the conduct of individuals or groups may be directed" (Foucault, 1982: 221). He goes on to argue that it is the symbiotic relationship between knowledge and power that gave rise to professions such as psychiatry.

The Rise of Psychiatry

Psychiatry emerged from the large numbers of state and private asylums, which provided a guaranteed market for the mad managers, who through a process of professionalization became known as psychiatrists. These men were in a unique position to define, capture and organise their market, providing themselves with the professional credibility to be exclusively qualified to deal with the mad, thus monopolizing the market (Scull, 1993: 41). Turner describes how occupations such as psychiatry go through a process of professionalization, whereby the acquisition of

specialist, technical knowledge is directed towards maintaining both the social system and the social status of the professional group (Turner 1995). By staking out areas of expertise and authority within perceived areas of social problems, the rising profession of psychiatry was able to secure its status and power, as Ingleby states:

> the professional experts who manage the "therapeutic state" enjoy not simply power, but authority: the medical model does not just define their practices, but supplies a framework that *legitimates* them. (Ingleby, 1983: 164)

There is a symbiotic relationship, therefore, between the rise of psychiatry as a profession and the identification, differentiation and segregation of the mad, as Scull notes:

> A dialectical process was at work, whereby the separation of the insane into madhouses and asylums helped to create the conditions for the emergence of an occupational group laying claim to expertise in their care and cure, and the nature and content of the restorative ideal which the latter fostered reinforced the commitment to the institutional approach. (Scull, 1993: 41-2)

Fundamental to the development of this medical hegemony was the conceptualisation of madness as a disease. For medics to monopolize the treatment of madness, they needed to oust competing groups and gain public confidence (Scull, 1993: 186). However, with the success of the moral treatment, which was in effect a common sense treatment administered by lay people, acquiring medical dominance was not easy. Many established figures argued against a predominantly medical approach for the treatment

of madness, stating that medicine had "little or no effect on the disease" (House of Commons 1815 and 1816 in Scull, 1993: 194-6). Ironically, medicine was helped to lay its claim to the treatment of madness through the weak professional ideology of the moral treatment (Scull, 1993: 216).[9] First, by rejecting science and expertise, and adopting a common-sense basis to treatment, those providing moral treatment found it difficult to construct a unified, professional identity. Indeed Tuke applauded amateurism, rejecting the need to provide a scientific rationale for his methods (Ingleby, 1983: 154). In other words, their methods were too obvious to constitute professional work (Scull, 1993: 199). Second, the discourse of moral treatment is grounded in medicine with terms such as treatment, patient and mental illness, for example. This eased the path for medicine to impose its authority. As Scull argues:

> Given the critical role of language in shaping the social construction of reality, to employ terms which imply that something is a medical problem, and yet to deny that doctors are those most competent to deal with it, seems perverse.
>
> (Scull, 1993: 200)

However, medics could not contest the success of moral treatment and in order to secure their dominance they incorporated moral treatment into a regime of possible medical treatments for madness. This was a shrewd move as they could counter accusations of abandoning a successful treatment, whilst at the same time reinforcing their dominant position as being the only profession able to deliver medical care (Scull, 1993: 229). This resulted in a series of legislation that confirmed the presence of medics and medical treatment in every asylum (Scull, 1993: 231).

[9] This is resonant of the resurgence of interest in the 1970s and 1980s in locating the causes of

Throughout the nineteenth century a process of professionalization began to occur. Following the defeat of the 1819 reform bill, further efforts were made to establish the treatment of madness within the medical paradigm. The treatment of madness appeared in medical training curriculum, annual lectures were published, influential people were lobbied, articles written for established periodicals, new specialist journals and professional organisations were formed, and specialist conferences convened.[10] Perhaps most importantly, medical certification of the insane was extended, enabling medics to extend their authority and their position to define mental illness (Scull, 1993: 207-10). However, the most effective way of ensuring medicine's dominance in the treatment of madness remained aligning madness with physical illness, thus placing its origins within the biophysical sphere, transforming moral and social problems into technical ones, so that; "the link with medicine provides the essential lifeline of respectability and trust" (Ingleby, 1983: 165). Some proposed that the mind was a function of the brain and, as such, there could be no such thing as mind or mental disease: instead, symptoms were synonymous with brain disease (Scull, 1993: 219). However, such positions were perceived as a threat to religious and moral order, as they challenged the divine immortality of the soul by conceiving the mind as being a product of brain activity (Scull, 1993: 220). Instead, a subtler argument was developed along metaphysical lines, whereby the mind (immortal and immaterial) operated in the mortal world through the medium of the material brain (Scull, 1993: 221). Once this metaphysical argument was accepted, medics embraced the somatic theories of the materialists that symptoms are a product of a faulty brain, not a faulty mind (Scull, 1993: 222). The discourse of the profession also developed whereby the technical terminology became increasingly

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schizophrenia within the brain (neo-Kraepelinism), in response to anti-psychiatry.

medicalized with the development of somatic metaphors (Scull, 1993: 238). A causative theory of brain lesions was developed, which, whilst unproven, was strongly defended on the basis of science and technology not being advanced enough to detect it (Scull, 1993: 223). This reliance on science to further the knowledge and treatment of madness was more than an offshoot of medicine; it was, as Ingleby argues, part of a much larger movement, namely positivism, which aimed to model human sciences on natural sciences (Ingleby, 1981: 28). The poor evidence base did not negate the positivist paradigm, rather it served to strengthen the search for both physical causation and treatment, a tradition that continues to this present day, and one that shall be explored further in the following chapter *Constructions of Madness*.

Criticisms of any failures in relation to the evidence base were offset by the large demand for asylum services, which were seen to benefit both the local community and wider society. The professionalization of asylum doctors did, however, effectively isolate them from their medical colleagues. The lack of convincing evidence, together with lower prestige, pay, and working conditions of asylum doctors, segregated them from generic medicine so that they were "within the pale of medical science" (Hayes Newington 1889 in Scull, 1993: 251). Asylum doctors began to feel as stigmatised as the people they were treating, the lepers of medicine. The elite among the mad doctors carved out a new niche for themselves with the neurotics, who were deemed more curable, came from a higher social class and could be treated outside of the asylum from an office (Scull, 1993: 255-6). Another strategy employed to raise the profession's prestige was to claim the success of moral treatment as its own, one which only medics could deliver (Scull, 1993: 260). However, as Scull argues:

[10] The British Journal of Psychiatry began its life in 1853 as the Asylum Journal (Moncrieff and

> where claims to the authority of expertise are themselves weak and tenuous…the quest to supplement this with the authority of office will require extraordinary urgency and importance. (Scull, 1993: 265)

As such, the pivotal strategy to ensure their dominant role in treating the mad was one where the medical superintendent had increased administrative powers and duties, delegating the medical care to assistant physicians (Scull, 1993: 266). Thus the higher the professional status in the asylum, the less contact with the insane, a practice some would argue persists to this day.

The rise of the scientific and technical discourse of psychiatry, together with its alignment to medicine, can be analysed within the indeterminacy/technicality ratio (Jamous and Peloille, 1970 in Turner, 1995). According to Jamous and Peloille, specialized, technical knowledge has two functions: first, creating prestige for the psychiatrist, thereby legitimising his actions, and second, by creating a social distance between the psychiatrist and the patient. However, to protect the knowledge base from fragmentation and devolvement to other disciplines, professional knowledge has to be indeterminate, esoteric and complex, so that it cannot be reduced to systematic or routinised knowledge (Jamous and Peloille, 1970 in Turner, 1995; Freidson,1970 in Ingleby, 1983: 153). It is the eclectic nature of this knowledge that has ensured the professional dominance of psychiatry, overcoming both theoretical and ideological challenges. Johnson argues that the greater the indeterminacy, the more distant the relationship, rendering the patient increasingly helpless in relation to the psychiatrist,

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Crawford, 2001).

thus allowing the doctor to operate without challenge (Johnson, 1982 in Turner, 1995). Therefore the authoritative position of the psychiatrist was not gained through scientific knowledge, but through a combination of power and perceived possession of knowledge. Foucault identifies five 'tokens of knowledge' that enabled the doctor to function as the authoritative figure in the asylum. First, the doctor infers that he alone knows the patient's biography intimately. Second, psychiatric questioning is constructed not to elicit information from the patient, but to reinforce and confer meaning to the doctor's body of perceived knowledge. Third, the patient is constantly supervised and recorded in a system of notes that are always available to the doctor. Fourth, punishment must be seen to be therapeutic. Finally, the clinic acts as a stage on which the doctor performs to others, displaying his knowledge to patient and students through the two-fold action of examining and teaching. Through the clinic, the psychiatrist becomes the authority of truth (Foucault, 2006b: 183-7).

The nineteenth century gave birth to what Castel refers to as the "golden age" of psychiatry, a period defined by three elements: the isolation of the mad; the construction of an internal order, legitimated by medical knowledge; and the subordination of patients by staff (Ingleby, 1983: 159). The end of the 1800s saw a need to extend the system of classification and its related treatments beyond the confines of the incarcerated. What emerged at the turn of the twentieth century was a system that, whilst stemming from the moral treatment, was based on regimes of oppression, subordination and conformity (Scull, 1993: 379).

Kraepelin and Twentieth Century Psychiatry

Of particular importance to the history of modern psychiatry is the history of schizophrenia, which emerges from Emil Kraepelin's seminal work *Textbook of Psychiatry*. The *Textbook*, which ran into nine editions between 1887 and 1926, was based on Kraeplein's longitudinal observations of over 1000 case studies and influenced modern psychiatry in four key respects. First, he took a naturalistic approach to the study of madness, taking his methods from the field of natural science with madness as its object. Kraepelin aspired to uncomplicated quantitative research methods, abandoning any speculative aspects of psychiatry (Hoff, 1995: 273). Second, he classified groups of symptoms, aligning them with different disorders, thus developing what came to be considered by psychiatry, a pragmatic and clinically oriented nosology. Third, Kraepelin argued that symptoms and therefore psychiatric disorders could, at some point in time, be causally related to different brain pathology or different aetiology (Bentall, 2003; Hoff, 1995). Fourth, and this is particularly pertinent to the women central to my research, Kraepelin identified a cluster of symptoms classified as dementia praecox which, as I shall outline in the following chapter, became known as schizophrenia. These four elements that underpinned Kraepelin's work laid the ground for the scientific focus in psychiatry and the categorisation of individuals within predetermined classificatory systems such as DSM. Importantly, Kraepelin's philososphy to the study of madness influenced both reactions against a Kraepelin approach by what became known as anti-psychiatry and, with the pendulum swinging widely to the other side, reactions to anti-psychaitry in the form of neo-Kraepelinism, as I shall now go onto discuss.[11]

Professional resistances to psychiatry

I am resisting titling this section 'anti-psychiatry', as although I shall focus mainly on the work of R.D. Laing, it is misleading to lump together leading critics of psychiatry such as Laing, Goffman, Szasz and Scheff under this term. These critics, whilst resisting orthodox psychiatry that followed the Kraepelin tradition, held very different perspectives. What they do have in common, however, as Sedgewick notes, is "a consistent and convergent *tendency of opposition* directed against *positive method* in the study of abnormal behaviour" (Sedgewick, 1982: 22, emphasis in original). Miller (1986) highlights three specific accusations made towards psychiatry from these and other critics. First, psychiatry has failed to alleviate mental distress through the use of institutions: second, it has facilitated the construction of mental distress as an illness, and, third, it has been excessively dependent upon medical expertise. These critiques challenged the very heart of psychiatry, the object of madness. Instead of madness being understood as biologically based, it was seen as socially caused and, for some critics, socially constructed. Rather than a humanitarian concern to relieve suffering, the goal of psychiatric treatment, medical or otherwise, was to maintain social order and to do this it engaged in practices of symbolic violence. The role of medicine was therefore viewed by some to be both unwarranted and unjustified (Ingleby, 1983: 143).

Whilst Foucault gave a historical interpretation of the emergence of madness and unreason, it was psychiatrists and sociologists in the USA and the United Kingdom who directly challenged the prevailing medical culture of the day. In America, this challenge was led by the sociologist Goffman and the psychiatrist Szasz. Goffman saw mental illness as embedded in the social context of institutions. As such, it was recognisable

[11] Interestingly, as Bentall observes, both the anti-psychiatry and the neo-Kraepelinism movements use

through patients' reactions to their environment, with both reactivity and adjustment to incarceration viewed as symptoms of mental illness (e.g. aggression and withdrawal) (Goffman 1991).[12] Szasz takes a broader perspective arguing that the social construction of mental illness occurs not only within the institution, but also in wider society. Szasz draws an analogy between physical and mental illness, arguing that it is nonsensical to talk of mental illness in the same way as physical illness as there is no pathology underlying it. Part of Szasz's dualistic argument is his contention that what is perceived as moral and scientific progress in respect to madness is no more than a shifting fashion of scapegoating, with the concept of mental illness fulfilling the same social function as did the concept of witchcraft in the Middle Ages (Szasz, 1997: xxiii). For example, the mad are held responsible for problems in social living; are defined and treated in the most part against their will; and suffer from threatened and actual violence (Szasz, 1967; 1997).

In Britain, the challenge to psychiatry came from within its ranks, with the psychiatrist R.D. Laing leading a small number of like-minded colleagues, namely Aaron Esterson, David Cooper and Leon Redler.[13] Laing's theories emerged and extended influence during the 1960s, a time that saw political and social structures challenged. In particular, the counterculture of the mid-to-late 1960s is reflected in his writings which touch on Marxism, psychedelic experimentation, critiques of mental institutions and

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biology, either its absence or presence, as a basis for their arguments, believing that the nature of madness can be resolved through biological research (Bentall, 2003: 151).

[12] Goffman's analysis is supported by other empirical evidence. Rosenhan conducted an experiment where eight pseudopatients presented themselves to hospitals claiming to hear voices (Rosenhan, 1973). All eight were admitted and their pseudo symptoms ceased on admission. Seven pseudopatients were given a diagnosis of schizophrenia, and despite ceasing to fabricate symptoms, their behaviour was interpreted to be in accordance with mental illness. Interestingly, the real patients were not fooled by this subterfuge, identifying the pseudo patients for the fakes they were.

[13] Laing's work is of pivotal importance to this thesis, being central to the analysis of the narrative of Mary Barnes (see chapter seven) and therefore is discussed in greater detail than the American critics.

social institutions (the family), Eastern mysticism, existentialism and psychoanalysis. Through his major works, in particular *The Divided Self*, *Self and Others* and *The Politics of Experience*, the evolution of his ideas can be traced. His first book, *The Divided Self* (1965, but originally published in 1959) is arguably his most popular publication that continues to influence current thinking on psychiatry. In the book, Laing critiques the Kraepelin-type positivism underlying psychiatry, arguing instead for a person-centred approach to medicine, as he describes:

> It is just possible to have a thorough knowledge of...just about anything that can be known about the psychopathology of schizophrenia or of schizophrenia as a disease without being able to understand one single schizophrenic. Such data are all ways of *not* understanding him.
>
> (Laing, 1965: 33, emphasis in original)

For Laing, empathic listening and understanding the meaning within language and behaviour take precedence over diagnosis-making. Using the example of schizophrenia, which by the 1960s had achieved an iconic status both in psychiatry and the public consciousness, Laing argues that it is a socially constructed phenomena, constructed in particular within the family.[14] The adult or child diagnosed with schizophrenia is, Laing argues, elected into this role within a 'good-bad-mad' pattern (good baby, bad adolescent, mad now). This parental pattern of labelling the child, Laing argues, threatens the child's ontological security, which may result in the individual retreating into psychosis. He suggests that this mode of being may reveal insights that those judged sane are not able to achieve. Whilst this book has little of the mysticism of later

work, it does explore existentialist philosophy in relation to inner experiences; for example in the chapters 'Ontological Insecurity' and 'The Embodied and Unembodied Self'. This existentialist framework led him to look at social relations in the family, reflected in the books *Self and Others* (Laing, 1961) and *Sanity, Madness and the Family* (Laing and Esterson 1964). However, it is his book *The Politics of Experience* where Laing's view on schizophrenia is most radical (Laing, 1967). In a book that delves into Eastern mysticism for explanations, Laing argues that schizophrenia, rather than being a breakdown, is a breakthrough, a journey to a primeval point of one-ness where liberation and renewal could be achieved. Here Laing states that the so-called 'normal' person is the one who is alienated from the true self, not the 'schizophrenic'. Throughout the 1960s, therefore, Laing's view on schizophrenia shifts from social criticism to eastern mysticism.

Laing's arguments in relation to psychosis were not merely theoretical, but were put into practice in his experimental therapeutic community, Kingsley Hall, which was aimed at guiding people through the journey of schizophrenia without medication.[15] In this setting, Laing attempted to shift the power from the medic to the patient, so that it was the patient that produced the truth about madness, as opposed to the psychiatrist. The work of Laing and the other co-founders of Kingsley Hall, most notably David Cooper, became known as anti-psychiatry. It should be noted, however, that this was a position and a movement that Laing was later eager to distance himself from, publicly stating that he was not an anti-psychiatrist but a psychiatrist and a physician,

[14] Laing's focus on the family echoes Foucault's analysis of madness and psychiatric power in that first, the family is the site where madness is precipitated and, second, madness cannot be cured within the site of the family (Foucault, 2006b: 98-9).
[15] Kingsley Hall will be discussed in greater detail in chapter seven.

apologising for any implication that madness was preferable to sanity (Sedgewick, 1982: 118).

Foucault argues that one of the consequences of anti-psychiatry was that it permanently called into question the role of the psychiatrist, particularly as the holder of truth about madness (Foucault, 2006b: 342). For Foucault, "the importance of anti-psychiatry is that it challenges the doctor's power to decide on an individual's state of mental health" (Foucault, 1973 in Lagrange, 2006: 353). In this sense, he proposes "the whole of modern psychiatry is permeated by antipsychiatry" (Foucault, 2006b: 342). Others have suggested less positive outcomes of this radical movement, arguing that there was a dramatic swing in the opposite direction towards Kraepelin's psychiatry. Claridge goes as far as to say that anti-psychiatry did a 'disservice' to attempts to correct a medically dominant paradigm:

> The Laingian analysis of madness, for example, although certainly reawakening us to the fact that there is meaning in the psychotic experience, went too far in that direction, neglecting the suffering of genuinely sick people, entirely ignoring an evident biology in mental illness, and confusing the notions of blame and cause in the determined search for an entirely sociogenic explanation.
>
> (Claridge, 2001: 93)

Claridge identifies two fundamental ways in which Laingian and other challenging ideologies helped to constrain thinking about psychosis. First, there was a resurgence in neurobiological research making the bio-medical model of psychosis "even more entrenched than it was before" (ibid). Thomas and Bracken (2008) argue that this

resurgence “rekindled the spirit of Kraeplin”, where nosology became aligned with neuroscience, exemplified in the ever expanding categories of DSM. Second, the polarised debate between traditionalists and dissenters implies that there are two positions on madness, diverting attention from other possible explanations. Crucially, it could be argued that professional resistance from within psychiatry has diverted attention away from the survivor or patient-as-expert voice, as another professional faction attempts to speak for the mad. However, it is important to note that these survivors/patients/the mad are not the passive recipients of power relations on whom power is enacted, rather they are people who have choices and are free to act. In this regard, within the power relationship there are numerous ways in which individuals respond and many possible outcomes of the relationship. Governmental power, therefore, does not oppose freedom, rather it incites individuals to express themselves in regard to choices (Thomas and Bracken, 2008). This is exemplified in movements such as Gay Liberation and Gay Pride (resisting homophobia and celebrating diverse sexualities), Black Power (resisting racism) and Hearing Voices Network and Mad Pride (challenging dominant conceptions of madness and celebrating madness). All of these movements are more than a singular act of revolution; together they embody the cultural process of liberation through an opening up of discourses. Power relations, therefore, have within them the possibility of escape, which gives rise to what Foucault refers to as confrontation strategies (Foucault, 1982). However, such freedom, choices and routes of escape are limited, being constrained by and conditional upon the normative terms dictated by society. For example, whilst a ‘schizophrenic’ has the freedom to act within his relationship with the psychiatrist, he does not seek out the distressing experiences that place him within this relationship. Moreover, such

freedoms are therefore contingent upon his given identity; an identity ascribed by another and not actively sought. As Thomas and Bracken describe:

> We do not control the ideas, constructions, words, and priorities of the worlds in which we live and grow. Instead, these representations present us with a picture of what it is to be human, to be normal, to be free. Wittingly or unwittingly, we are all bound by them. They hold our conduct within certain limits, but also incite us in certain directions and ultimately present us with a vision of what liberation and freedom are all about. (Thomas and Bracken, 2008: 36)

Thomas and Bracken highlight a third consequence of anti-psychiatry: the move from mass hospitalisation to community care, which was instigated through social policy, was viewed by psychiatry as a means of distancing the profession from the negative views of the asylum. The negative representation of asylums and psychiatrists reflected by theorists such as Goffman, Szasz and Laing, together with critical novels and films (e.g. The Snake Pit, The Bell Jar and later, One Flew Over the Cuckoo's Nest, with the madman as an existential hero), adversely affected the identity of psychiatry. A shift from institutional to community care gave psychiatrists greater opportunities to improve their professional standing, gaining professional power, status and improved career structures by functioning in the wider community of medicine (Rose, 1986: 55). Rather than patients wanting to be desegregated (a group who are rarely in a position to direct services) it was in fact psychiatrists that had much to gain by such a shift. However, the move from institutional care to community care was by no means wholly positive. Whilst on the surface appearing to be progressive, community care has taken on some of the institutional thinking and practices from the asylum; for example, the forced

administration of medicine and supervision orders. Moreover, Thomas and Bracken argue that community psychiatry has created a new class of non-citizen, the revolving door patient, who lives within a variety of disciplinary spaces such as hospitals, bail hostels, prisons and so on (Thomas and Bracken 2008). Such individuals have high public visibility, transforming community psychiatry for some people into community policing.

The legacy of anti-psychiatry is therefore ambivalent. It pre-empted the resurgence of the biomedical model, with much of funded research continuing to focus on biochemical, genetic and neurological explanations (see chapter three); and whilst being a catalyst in the closure of large asylums in favour of community care, it was a form of care that transferred the governance of subjectivity from one space to another. However, what should not be lost sight of was that as a radical movement, anti-psychiatry was successful in shifting the political consciousness of many individuals, in particular service users and survivors, authorising the right to challenge psychiatry about its claim to speak for madness.

Postpsychiatry and governance

Rose warns against dichotomising the political polemics of psychiatry, with the reactionary "medical model" at one end and the progressive social theory at the other (Rose, 1986). Such a simplistic analysis, he contends, "profoundly misunderstands contemporary psychiatry" (Rose, 1986: 45). Castel likewise warns against making simplistic attacks on modern psychiatry, arguing that a schematic shift has taken place for most psychiatrists, which is:

> composed of a feeling of underlying solidarity with the patient, of suspicion of a conformist definition of normality, and of political critique of the role played by a repressive social structure in the aetiology of mental illnesses.
>
> (Castel, 1983: 262)

Ingleby advises that movements such as anti-psychiatry need to be grounded in the philosophy of anthropology, respecting:

> the autonomy and internal coherence of the "foreign" culture, and the impossibility of simply invalidating one mentality from the standpoint of another. (Ingleby, 1981: 25)

By attacking the harsher end of psychiatry (involuntary incarceration, ECT, psycho-surgery and chemotherapy, for example) the anti-psychiatry argument contributed to the emergence of alternative forms of treatment, what Rose refers to as "therapies of normality": therapeutic communities, family therapy, behaviour therapy, psychoanalysis and counselling (Rose, 1986: 80). Present day mental health care therefore continues the tradition of cure and normalization. As Rose describes it, present care is "suffused with the ethic of the humanist, the ethic of the normal social person" (Rose, 1994: 67). Not only did the anti-psychiatry debate therefore shape the development of psychiatry, Rose also argues it contributed to the extension of psychiatric populations and problems, resulting in personal unhappiness becoming an object for treatment (Rose, 1986: 83). This "psychiatricization" of the whole population, as Ingleby refers to it, potentially occupies a portion of everyone's mind (Ingleby, 1981: 44). Conrad, writing in 1981, argues that such is the dominance of medicine in psychiatry that the medicalization of

social problems removes them from the realm of public discussion, leaving social problems only for expert dialogue (Conrad, 1981:119). However, the past quarter of a century has witnessed a shift in how social problems and mental distress are talked of in the public domain. In our everyday lives, psychiatric discourse has a strong populist presence today, in what Rose describes as a "secular value of health" (Rose, 1994: 67). Attaining both physical and mental fitness has become a daily pursuit, with well-being as a religion and the doctor, rather than the priest, attending to our needs. This search for optimum health has become an existential quest, bound up with who we are and what it means to be human, as we are urged to improve, regulate and master our own well-being (Rose, 1994: 68). In the media, radio and television chat shows focus on personal experiences, from rape to relationship problems. Soap operas portray scenarios of mental distress, whilst newspapers, particularly the tabloids, communicate powerful messages related to both celebrity and non-celebrity mental health. Such is the dispersion of psychiatric discourse in our social world, that it is now acceptable to seek help for almost any life event: marriage, divorce, child rearing, employment, unemployment, retirement, bereavement, together with the shelves of self-help books to guide us through these events. As Rose (1986) states: "no phase of life is unknown to psychiatry…psychiatry provides us with the very terms in which our problems are constituted" (p. 43). Psychiatric terminology has therefore ceased to be solely the province of the experts, being a language we all use to frame our personal unhappiness.

More than ever then, contemporary psychiatry is in a position to manage the mental well-being of society, not only by treating those diagnosed with a serious mental illness, but also those with minor mental health complaints, regardless of whether psychiatry is best equipped to deal with these problems (Conrad, 1981: 119). By promoting good

mental hygiene through education, early detection and treatment, there is a belief that many social problems are preventable (Miller and Rose, 1986: 1). Moreover, under the concepts of early detection and prevention, psychiatry is encouraged to seek out those not presenting themselves to services, those who do not consider themselves as sick, carrying responsibility for not only those psychiatry has contact with, but also those it does not. Szasz argues that this extension of psychiatric governance and police power is a modern psychobureaucracy specifically "set up for the express purpose of manufacturing mental patients" (Szasz, 1997: 225). At the turn of the twenty-first century we are witnessing a reclamation of governmental ground and state control in the treatment of the mad in what has been described as "some of the most repressive psychiatric legislation of recent times" (Moncrieff, 2003: 8). New psychiatric conditions have been constructed and defined by the present Labour Government ("dangerous severe personality disorder"); the 2002 Mental Health Bill proposed an extension of state controlled compulsory powers through tribunals which will have the power to force doctors to treat patients, regardless of whether doctors deem it appropriate; and in a culture where "concerns of risk will always take precedent", compulsory detention or treatment is set to increase, whilst discharge routes decrease (Department of Health, 2000). Thus the asylum has had a postmodern metamorphosis into a range of new forms of control; secure and high dependency units, closed-circuit television monitoring and electronic personal alarms. Furthermore, the relationship between madness and crime is ever prevalent, with media coverage reinforcing this by implying a causal relationship between the two. This is a deeply entrenched cultural theme and, as Foucault outlined, such public coverage is not aimed to demonstrate that every criminal may be mad, but that every mad person may be a criminal (Foucault, 2006b: 250). This, Foucault argues, is a means of establishing psychiatric power not in

relation to truth, but in relation to danger. Part of psychiatry's function and power therefore, is to protect society.

However, Rose argues that it is the increased psychiatrization of everyday problems that needs critical examination, rather than viewing contemporary psychiatry as another form of medical social control (Rose, 1986). Miller and Rose also argue that with the widespread closure of psychiatric hospitals and the development of community psychiatry, the anti-psychiatry debate has, in recent years, lost some of its persuasion (Miller and Rose, 1986: 2). This may be so, but contemporary psychiatry, its growth into the community and the concern with risk and dangerousness which is reminiscent of the mass confinement of the eighteenth and nineteenth centuries, has led to a new critical debate, one which has united the profession of psychiatry and critical pressure groups in opposition to new mental health legislation.

In sum, the last century has witnessed a continuation of the historical tradition of the scientific interpretation of people's experiences; a tradition that delineates the boundaries of research, setting out clear criteria for what is considered normal subjectivity. Within this positivist tradition, psychiatry has also been engaged in promoting mental health and well-being, extrapolating the social and psychological factors underpinning mental distress, working alongside non-medical professions such as psychologists and social workers (Miller and Rose, 1986: 1). It could therefore be argued that psychiatry contributes to the social capital of individuals and society, so that mental health becomes "a national asset, an economic advantage, a social necessity and a personal desire" (Miller and Rose, 1986: 4). However, this has resulted in an extension of the power held by psychiatry. From its privileged position, psychiatry is

now able to comment and advise upon the whole spectrum of individual and social life, creating a new form of social governance and reinforcing the inter-connection between medicine and government. Bracken and Thomas (2001; 2005) argue for a profound cultural shift in psychiatry in order to avoid becoming further embedded within this state control. They argue that social, political, cultural and historical contexts should be central to understandings of madness; that meaning and interpretation be given priority; and that biology steps down from its privileged position to make space for alternative explanations:

> [Postpsychiatry] does not propose new theories about madness, but it opens up spaces in which other perspectives can assume a validity previously denied to them. Crucially, it argues that the voices of service users and survivors should now be centre stage. (Bracken and Thomas, 2001: 727)

It is both traditional and alternative perspectives that I turn to next in the chapter *Constructions of Madness*, which explores the differing paradigms in which the construct schizophrenia is framed.